S. HRG. 102–712

# BETTER ACCESS TO AFFORDABLE HEALTH CARE

## HEARING

BEFORE THE

## COMMITTEE ON FINANCE
## UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

ON

## S. 1872

FEBRUARY 20, 1992

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# BETTER ACCESS TO AFFORDABLE HEALTH CARE

## THURSDAY, FEBRUARY 20, 1992

U.S. SENATE,
COMMITTEE ON FINANCE,
*Washington, DC.*

The hearing was convened, pursuant to notice, at 10:04 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Moynihan, Baucus, Bradley, Mitchell, Riegle, Rockefeller, Daschle, Breaux, Packwood, Danforth, Chafee, Durenberger, Symms, Grassley, and Hatch.

[The press release announcing the hearing follows:]

[Press Release No. H–5, Feb. 4, 1992]

HEARING PLANNED ON BENTSEN ACCESS TO HEALTH CARE BILL, CHAIRMAN WANTS MORE AFFORDABLE INSURANCE FOR AMERICANS

WASHINGTON, DC—Senator Lloyd Bentsen, Chairman of the Senate Finance Committee, Tuesday announced a hearing on the Better Access to Affordable Health Care Act, his bill to make it easier for Americans to get and keep health insurance.

The hearing will be at *10 a.m. Thursday, February 20, 1991 in Room SD–215* of the Dirksen Senate Office Building.

"Americans who work hard all day shouldn't have to worry about how they are going to pay the bills if they or a loved one gets sick. Sadly, though, more than 34 million Americans have no health insurance and must live with the nagging fear that comes from knowing they need insurance that is out of their reach. About four out of every five of these persons have jobs but most work for small businesses—companies with fewer than 50 employees—which are facing an insurance squeeze of their own," Bentsen said.

"I have introduced S. 1872 to make it easier for Americans to have health insurance. It would prohibit insurers from 'cherry picking' by denying coverage to workers and dependents who need insurance most, combat 'joblock' and make it easier for employees with health conditions to get a better job without losing family coverage, and help make less expensive health policies available to small businesses by relaxing restrictions on the kind of benefits insurance companies must offer," Bentsen said.

"I'm calling this hearing to solicit views on how this legislation would help ease these problems and give Americans the assurance that they can have access to health insurance when they need it," Bentsen said.

## OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. If you will cease conversation, this hearing will get under way.

The dual problem of rapidly rising health care costs, going into double digits every year, and the decreasing availability of health insurance is one of the major problems facing this country today.

It is a big question in the Presidential and Congressional debates. Today there are over 35 million Americans without health insurance; almost unanimous agreement that the status quo cannot continue.

There is no shortage of proposed solutions, but, also, there is no agreement thus far either in Washington or amongst the American people on what direction should be taken.

The debate over reform of the health care system has begun, but it is going to take some time to get it accomplished. Last fall, I joined with Senator Durenberger, Senator Mitchell, Senator Rockefeller, and others, in introducing S. 1872, the Better Access to Affordable Health Care Act.

We focused on some problems in our health care system for which there is the greatest consensus now for action. We intend to move forward as quickly as possible to address some of the more egregious problems in those areas now while this important debate over comprehensive health care reform proceeds; not as a substitute for such, but an interim step.

Let me summarize briefly the most significant provisions of the Better Access bill. It would attack the problem of job lock by limiting the extent to which workers and their dependents would be excluded from coverage because of pre-existing conditions as they changed jobs and insurers.

There are so many instances where a man or a woman cannot change jobs because they have a spouse or they, themselves, have some pre-existing condition.

The other thing we address is the cherry-picking by some insurance companies, where they will come into a small employer who might have 25 employees and they say we will cover the 24, but we will not cover this one that has the heart condition, and that is the one that needs it the most. Or that the next time that premium comes up, they jack it up to an extent where it forces the employer to drop the insurance.

The Better Access bill would also create an ongoing Health Care Cost Commission to advise the Congress and the President on strategies for reducing health care costs. Members would be drawn from health care consumers, providers, insurers, and employers.

Affordability for small business would be addressed through flexible benefit packages; a grant program to assist States in developing group purchasing programs for small businesses; and an increase in the tax deduction for the self-employed from 25 percent to 100 percent. That employer now has that for his employees, but he has a limitation on himself of 25 percent.

Finally, S. 1872 would expand Medicare benefits to cover cancer screening and other preventive services. Prevention is a critical, yet often overlooked element in our health care system.

The Congressional Budget Office estimates that over 13 million Medicare enrollees would benefit from these services. As of this morning, we have 24 Senators co-sponsoring this piece of legislation. It has bipartisan support, including Senators who have also co-sponsored various comprehensive reform proposals.

The health care reform plan announced by the President earlier this month included provisions for limits on pre-existing condition exclusions and small group insurance reform that are, according to

the administration's spokesman, identical to those in this piece of legislation.

It is my hope that we can move on S. 1872 soon—very soon—and that this hearing will allow our committee to benefit from comments on the bill from a wide range of perspectives. I look forward to receiving guidance from the witnesses.

I now defer to the Ranking Member on the committee, Senator Packwood.

## OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Chairman, your assessment is correct, both as to the problem, and, I think, as to the consensus. There is obviously a significant difference of opinion among members of Congress on what overall health reform should be, but I do not find much difference on insurance reform dealing with access and affordability for small business.

It is in the bill that I have introduced; it is in your bill; it is in the bill of almost everybody else that has put in a health reform bill in Congress.

I have one concern, and I hope we can address this, regarding flexibility to States, like Oregon, who want to experiment and are attempting to innovate in health care reforms. Any small business health care reform bill should give discretion to the States to design their own basic benefit packages and insurance standards to meet the needs of those States.

And the reason I emphasize that, Mr. Chairman—and you are aware of what Oregon wants to attempt in the delivery of health services—is no other States have indicated they are willing to try it yet. I hope we can accommodate Oregon's wishes in this legislation.

The CHAIRMAN. Thank you. I call now on the Majority Leader for any comments that he might make.

## OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Well, Mr. Chairman, thank you very much for holding this hearing. I commend you for introducing the legislation, the Better Access to Health Care Act.

It will make reforms in the small group insurance market and gives small businesses certain tax advantages in an effort to encourage more employers to provide health insurance to their employees.

Our health care system is in crisis. Nearly 37 million Americans do not have health insurance, yet the cost of health care to our society continues to soar.

It is not enough that we find a way to add those who are uninsured to the existing system; we must make fundamental reforms in that system, including, and, most especially, effective cost control, as well as the insurance market reform being proposed here.

This bill, of which I am a co-sponsor, is a first step toward addressing the problems facing millions of working Americans who do not have health insurance. And I am pleased, Mr. Chairman, that you have indicated you regard it as that—an interim measure.

The legislation will begin to eliminate some of the most serious problems facing small businesses and their employees in the purchase of health insurance. While it is a first step, it is a welcome one. I also believe that beyond this legislation, we must do more.

Over the last decade, a variety of cost containment strategies have been attempted by both the government and the private sectors. They have had mixed results, but, overall, there appears to have been little impact in the growth in total health care spending.

In our effort to contain health care costs, which must be our highest priority, we must have better information about what we as a society want to pay for. We must assure that each dollar spent provides the best return.

I believe we can get more value for the hundreds of billions of dollars we are spending as a society than we are now getting. It is estimated that between 10–30 percent of treatment for illnesses provided by physicians is either unnecessary or ineffective.

The Outcomes Research initiatives being conducted through the Agency for Health Care Policy and Research will improve the quality of care, while reducing unnecessary or ineffective treatment.

I am pleased that Senator Bentsen's legislation includes an expanded effort for outcomes research and the development of practice guidelines similar to provisions contained in S. 1227, comprehensive legislation which I, and other Senators introduced earlier this year.

I repeat that I think that this is a good first step, but that I believe more comprehensive reform is needed this year, and I will press for enactment of comprehensive legislation during this Congress.

Access to care and the soaring costs of care must be addressed. The loss of health insurance does not only affect the poor and the unemployed; an increasing number of middle-income working Americans and their children have no health insurance, or are just a pink slip away from losing their health insurance.

And one of the most striking things to me, Mr. Chairman, as I have gone all around the country to hear testimony on this subject, is the extent to which people who have insurance are suffering from fear and anxiety.

We make a serious error if we regard the health care crisis solely or even primarily one of dealing with persons who do not have health insurance.

It is a crisis for the millions who have health insurance but who are worried that they will not be able to afford it in the future, or that the coverage that they have will not take care of whatever illness or disease they or their children may confront.

I think the real issue overall is peace of mind—peace of mind for those Americans who do not have insurance and need it; peace of mind for those Americans who do have insurance, but are afraid of losing it. And I think that covers just about everybody in our society.

Mr. Chairman, I look forward to working with you and the other members of the committee to enact this bill and to enact comprehensive legislation reforming our health care system in this Congress.

The CHAIRMAN. Senator Moynihan.

## OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Mr. Chairman, I am a co-sponsor of your bill, and would wish to be so known.

But I had thought that possibly in this cycle we might raise the subject which seems to me to be the most significant problem of health care in our country—I mean the most visible problem, which is the mentally ill homeless.

I mean, if we were to ask what our Nation is known for around the world, it is for homelessness. And if you ask where it comes from, however, you get this muffle.

And I happen to think that this is—and no one is going to hear me on this subject because we are all into insurance—a government-created problem.

I was present when it happened, as we moved towards de-institutionalization in the early 1960's, following a Congressional commission in the 1950's. We overestimated the power of the tranquilizers; we overestimated the capacity of community mental health centers to help people, and then we forgot what we even started. And the next thing, you look up, and we have the problem of the homeless and people are beginning to find it as a problem of housing. I wonder if I could not ask my friend, Senator Packwood; you have a problem of homelessness in Portland, do you not?

Senator PACKWOOD. Everybody does.

Senator MOYNIHAN. Everybody does, because of the schizophrenics. Everybody has schizophrenics. It is not rent control, it is not this or that. Schizophrenia has a common incidence in all populations, and we emptied out those mental hospitals.

We took the advice of doctors who were perfectly good people, who overestimated their sights. And then we reduced the institutional care by 80 percent.

And a generation later, these people turn up with shopping bags and are living on grates, which is what they had done in the time before we created mental institutions.

And we do not know how to say what a mistake we made. The psychiatric profession is very muffled on this; very muffled. There is a measure of malpractice by the government here. I would hope we might find a way to address it. I mentioned to Secretary Sullivan the other day that it was not in his address, and not in any previous address.

Probably we are not going to do this, but I think we might think of doing it, because I think this is what most visibly and tangibly needs to be done.

These people are sick and they are sleeping on streets. And they used to be sleeping in beds. It is not like we have moved forward; we have regressed. And, with that screen, sir, I want to record myself as your co-sponsor.

The CHAIRMAN. Thank you very much. Senator Durenberger, your comments.

## OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you very much. Two weeks ago I said I thought that the President's health speech

and his plan was the end of the beginning of health reform, and now that we had heard from every quarter, it was time to finish the air war and start the ground war of health reform.

So, I am here to thank you, Mr. Chairman, for beginning the action phase of this process by initiating this hearing on insurance reform, and your commitment to mark up a bill soon.

There are three very good reasons why this committee should immediately report out S. 1872 and push it through the Senate floor without delay.

First, what health reform needs now is not more emotion but more motion. We have a system which has a host of difficult and interrelated problems that are showing up in the pain and uncertainty that every member has felt from millions of American families and businesses.

We do not have a lot of financial resources or political capital to put against those problems, so that means we have got 5 or 10 years of hard work to do to turn the whole thing around, including the problem that our colleague from New York talked about.

So, the question simply is, why delay the effort any further? We could either try to pacify people with gimmicks, or we can take genuine steps to solve their problems.

This bill is a genuine step toward greater access by more fair coverage and lower costs without compromising quality of care, and we ought to take that step.

The Majority Leader has already pointed to the political problem for people who are up for re-election this year: it is not just the uninsured; it is the insured, and the fact that insured all over America are paying radically different prices for the very same product and they do not understand why. And this is an effort to rationalize that system.

The second reason we ought to move is because the America people benefit far more from a bill that passages than from a package that sells. We have all the packages on the table now. We have Mitchell, Kennedy, Rockefeller, Riegle, Chafee, Dole, the President's, Senator Packwood's; a variety of them. What major reform do they all have in common? Small group insurance reform. And that should be the end of the argument.

But there are some on both sides who argue that we cannot pass any of the parts, we need to hold out for our whole package.

In practical terms, that means we will probably end up with stalemate rather than with action because, short of capitulation, there is no hope for a partisan package.

This bill is a bipartisan package. It will do good for people; it will point the system in the right direction; and it will build momentum for the next step.

The third point, and the last one, is simply, we are going to have to choose between politics and progress. And, Mr. Chairman, you have made that choice.

There is simply no way we can hope to take on a problem of this magnitude with one hand tied behind our backs. There is no Republican plan that is going to solve it; there is no Democratic plan that is going to solve it. Neither the Congress, nor the President alone is going to make a dent in this problem.

From April of 1989 to March of 1990, five members of this committee, eventually led by our colleague from West Virginia, Jay Rockefeller, and six members of the House of Representatives—the best political health minds on Capitol Hill—spent a whole year trying to find out what was politically feasible in terms of system reform.

And, by an eight to seven vote at the end of that process in March, we found out that there was not, as of then, a political consensus on what was politically feasible.

But in this call for action—which is the message to all the rest of the politicians, including ourselves—that came out from the Pepper Commission, there was the beginning of solutions, both to the political and the real problems.

Insurance reform would get to 75 percent of the coverage issue. It will not do it all, but it will begin to get us there. And that is the reason that, as soon as we finished our work in March of 1990, people on my staff—particularly Kathy Means, who is now at HCFA, and Dave Gustafson, who was then on loan from PBGC and is now back at PBGC—went to work with a lot of these staff people on trying to design appropriate insurance reform, because we thought we could get 75 percent of the way to the charge of the Pepper Commission.

I introduced the first product of their work in S. 3260 in October of 1990. The refined product was S. 700 in 1991. And today it is incorporated into the Chairman's bill, S. 1872; it is included in my Republican colleagues' bill, led by John Chafee, S. 1936; and it is in a lot of bills around here.

I just conclude, Mr. Chairman, by saying let us walk before we run, and let us have Republicans and Democrats in the walk, and let us have the President in on the walk.

We agree on the need for insurance reform and the value of this bill to meet that need. So, let us put our emotions, and our packages, and our politics aside and do something helpful for the people of this country.

[The prepared statement of Senator Durenberger appears in the appendix.]

The CHAIRMAN. Thank you. Well done. Senator Breaux.

## OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you very much, Mr. Chairman. I am pleased to join with many others who have co-sponsored your legislation as a major start in the right direction.

I think it is important, as we hear our witnesses this morning, to remember that, of the 39 million or so Americans that have no insurance, these are not just the indigent people who do not have jobs whom we see on the street.

The statistics show that approximately 80 percent of those who do not have insurance in America are working people; people who work every day in order to take care of their families and find out that they cannot even provide for some of the very basic needs that any family in our country, and that is to take care of their health needs.

That surely is an unacceptable standard for Americans in the 1990's, and that is not even to mention the large numbers of people who are underinsured with less than adequate insurance to take care of their very basic needs.

I think it is important to note that most of these people are in small businesses, and this legislation directly addresses that particular problem.

It is also, I think, very disturbing to note, Mr. Chairman, the trend that we see happening in this country in large companies where they are now moving towards hiring more and more part-time people.

I mean, everybody works for 35 hours these days when you are working for large stores so that the stores and companies that are large businesses do not have to provide insurance because their employers are all part-time workers.

We are finding companies now are 100 percent part-time workers so that the company gets out of the obligation—maybe because they cannot afford it, or maybe because they do not want to do it—of providing for some of the very basic needs of their employees. That, I would also argue and submit, is unacceptable for America in the 1990's.

A final point. My own State has the third-highest percentage of uninsured workers of all the States. Over a million people in Louisiana have no health insurance, which is unacceptable.

And many of those people—25 percent of them—are children in my State, which is double the national average; children who have no place to go as far as health insurance is concerned.

It is interesting also, I think, that the statistics show us about 40 percent of all children live in families that do not have employer-based health insurance. That is 40 percent of all the children in America—again, something that is unacceptable.

The challenge is there, the need is there, and I think the Chairman's bill is a major step towards helping to solve this very serious national problem. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller.

## OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Mr. Chairman, I would submit my statement for the record, which is the most welcome statement I can make, I know, as far as the Chairman is concerned.

But this is important. I agree with David Durenberger that it is time to put differences and politics aside. I am proud to be a cosponsor of this legislation.

There are a lot of things in this legislation that are very important, and there are some things that do not happen. But I think, as Senator Mitchell said, it is a very important place to start.

I think it is necessary for people to understand that guaranteed issue guaranteed renewability and especially the rating reforms, are very, very important. Obviously some of these reforms will actually increase the cost of health insurance for some small businesses, particularly the young and the healthy.

I think that the insurance industry, as a whole, does understand that the government has to be a part of this now in terms of changing the rules to make the playing field level.

I have introduced, with Senator Mitchell and others, insurance reform that comes out of the same Pepper Commission that Senator Durenberger referred to, and I think we just somehow have to make this work as best as we possibly can, and as soon as we possibly can. Thank you, Mr. Chairman.

[The prepared statement of Senator Rockefeller appears in the appendix.]

The CHAIRMAN. Thank you. Senator Daschle.

## OPENING STATEMENT OF HON. TOM DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. Thank you, Mr. Chairman. I want to commend you for your leadership in calling this hearing and for drafting the legislation of which I, too, am a sponsor.

I think there is a difference between comprehensive reform and a comprehensive list of incremental changes which are designed to bring about incremental reform.

And I believe that this is probably at the top of the list with regard to that comprehensive list of incremental changes; it is a very important function of reform.

What the President proposed two weeks ago, in my view, was a comprehensive list of incremental changes, all of which will bring about some measure of reform.

But the bottom line is that we are going to be judged by how well we do in addressing five very specific health care problems. The first is access: can we provide universal coverage?

The second is cost: can we stop the proliferation of cost in health care? The third is allocation. Right now in every society, health care is very much like a pyramid where you provide the basic primary care—the preventive care—at the base of that pyramid.

And, as you work your way up, you become more sophisticated until you get to the very top of the pyramid with bone marrow transplants and heart transplants.

Every other society provides care at the base of the pyramid and they work their way up until the money runs out. And then you either wait or you do not get care at the top of the pyramid.

The United States does just the opposite. We work from the top down. We provide top-of-the-pyramid care and work down until the money runs out. And that is one of the reasons why our health care system is so expensive.

The other is the allocation of dollars to paper work. We have a gas guzzler health care system. That is really what it is. It is a gas guzzler system.

It does not get us very far down the health care road to provide the kind of care it is supposed to. We spend 20 percent of our costs in health on paper work. It should not be that high; it should be half that, at most. Every other system has been able to do that. So, a gas guzzler system is one of the things we have got to address.

I think the fourth problem is unnecessary care. There are a lot of reasons why unnecessary care is provided, but, as the Majority Leader said, if we are providing 30 percent of our care today which

is unnecessary, we are talking about $240 billion this year in care that ought not be provided.

Part of that is because of defensive medicine; part of it is because of technology; part of it is because of fee-for-service; part of it is because we have proprietary interest in equipment and clinics; and part of it, as well, is the fact that people do not ask questions.

They will ask more questions about buying an automobile than they will about getting health care to be provided.

And the fifth problem is hassle. It is the frustration level that people are experiencing today. If we cannot bring down their frustration level, that of providers, as well as patients, then I think we will have failed as well.

I think this bill takes us down the road in dealing with those five issues. It is an incremental change. It is an important incremental change, but it gets us started.

And, in the spirit of Senator Durenberger's and Senator Rockefeller's comments about bipartisanship, I think the sooner we get at it, the better. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Baucus.

## OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. I think we all agree that this is an excellent first step and I commend you for it. I think that S. 1872 is a bill that makes good sense.

I might just anecdotally relate the degree to which I think it helps. When I was home in Montana last week, I spent a day working in a hospital.

Then I talked with several small companies and asked them about their insurance programs and how they handled insurance, and so forth.

One company's representative told me that their premiums went up 50 percent last year; just in 1 year's time. The owner of the company explained to me—it is a small contracting firm; they have about 10–12 employees—how he wants to provide insurance for his people and his employees' dependents, and how so many of his colleagues in the industry just cannot and do not because it is so expensive, but he is going extra lengths to be sure that he does.

His premiums are $40,000 for 10 employees. He has got to pay that. And another insurance company contacted him and said that that premium would not go up 50 percent if he, the employer, let go 2 of his employees that have pre-existing conditions. He would not do that. He would not let his employees go. But his premiums would not go up 50 percent if he would do so.

And that is very representative, at least in my State. Twenty percent of the people in my State of Montana do not have insurance at all. And, in addition to that, over half of the employers in my State are small businesses of four or fewer people.

And so, the legislation that you are presenting to us today goes a long way in addressing the problem that so many people in my State—I am sure Texas is very similar because it has a lot of small businesses, too—is, indeed, coverage, and better coverage. I mean, the cherry picking that goes on is unconscionable.

And, as others have said, this legislation is not going to solve the whole problem, but it is going to begin to solve a lot of the problem, and I commend you for it, and I hope we can pass it quickly this year. Thank you.

The CHAIRMAN. Thank you. Senator Hatch.

## OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Thank you, Mr. Chairman. It is a privilege to be here, and I appreciate you holding this hearing.

I have to tell you that unless we do something about Medicaid reform, Medicare reform, medical liability reform, anti-trust reform, and insurance reform, we are not going to get to any real effective solutions in the field of health care.

With regard to Medicaid, if it were me, I would quit saddling the States with 50 percent of the payments and I would make it a total Federal responsibility and give the States some other obligations that they have a whole responsibility on. But I think the current system is in chaos.

If you do not do something about medical liability reform and defensive medicine that is driving this whole system, you are not going to make any real inroads on trying to resolve costs, or quality, or even affordability.

So, I think that is important. This bill does a great deal about insurance reform and is a good start, as far as I am concerned, in trying to at least resolve some narrow areas of our health care needs.

I also think we have got to emphasize—which this bill partly does—basically health promotion and disease prevention, and all kinds of testing that needs to be done in order to foretell and catch health problems before you go too far.

I agree with Senator Durenberger, Senator Daschle, Senator Rockefeller, and others who say we should respect each other's views and values, and, for the good of the American people, do our best to reach an acceptable solution that takes these values into consideration.

So, in that spirit, Mr. Chairman, I think there is much to say in favor of your bill, particularly in the area of small market reform. There is great similarity between S. 1872 and many other health reform proposals.

The President's proposal also encourages small market reform, and, although not 100 percent identical in detail and, in fact, broader in scope, the plan of the Senate Republican Health Care Task Force is consistent with the spirit of your bill with S. 1872, as far as your bill goes, Mr. Chairman.

Now, a major concern that I have with your bill after we iron out the nitty gritty details is whether it goes far enough.

And do not get me wrong, Mr. Chairman, I commend you for putting this piece of legislation on the table, and I recognize that, given the difficulties of election year politics, even this piece of legislation may prove too much for us.

But let me just say, Mr. Chairman, that I support the intent of your legislation and I am committed to working closely with you and other members of this committee, as well as others, to fashion

our best efforts into a truly bipartisan solution to what seems to be an intractable problem to our society.

Not to support these types of reform would be a mistake, but to support only these reforms would also be a mistake, because these are not going to solve our health care problems, or the five or six goals that Senator Daschle mentioned, not to mention some others.

Now, to fix the health care system more completely, other corrective measures have to occur, and they are needed. These range from community health centers and reforming the medical liability system, to the question of how to ensure that the proper incentives are included in our health care financing system.

Now, we have got to start this job somewhere, and I want to go on record as stating that S. 1872 is a much more promising avenue than the so-called Health America bill.

And I am afraid that the Health America bill would not only worsen our already threatened economy, but would also tear at the fabric of our society by pitting small businesses against large; young against old; and the well against the sick. And I have no doubt about that.

Mr. Chairman, I commend you for your efforts to address the serious problems in our health care system and I look forward to working with you in this effort and to hearing from other witnesses today. And I would ask unanimous consent that my full written remarks will be placed in the record.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. That will be done, Senator.

We had previously scheduled Senator Bumpers at this time, but he is tied up in another committee and we will take his statement for the record.

[The prepared statement of Senator Bumpers appears in the appendix.]

The CHAIRMAN. But we are very pleased to have Senator Bond here, a U.S. Senator from the State of Missouri.

## STATEMENT OF HON. CHRISTOPHER S. BOND, A U.S. SENATOR FROM MISSOURI

Senator BOND. Thank you very much, Mr. Chairman. I appreciate the opportunity to come and present my ideas to you and the committee today.

I believe it is quite obvious from what has already been said that health care reform is a vital priority, one on which we must move forward very quickly.

And I believe that reform on the small insurance market is an area which you have properly identified as one which can develop bipartisan support and move quickly, and I particularly commend you, Mr. Chairman, Senator Durenberger, and other members of the committee, for bringing forward this measure you are considering today.

There is, as has already been mentioned, a wide variety of issues, challenges, and problems in the health care system. But I am here today to suggest to you one approach dealing with what you described as the egregious problems in insurance and the health insurance market, and I have several co-sponsors of the measure. We

are completing the redrafting of it at legislative counsel, and I expect to introduce it Friday or Monday.

But I believe this fits in very closely with the philosophy of your bill. I would hope that you would be able to consider it in marking up this bill. It deals with two aspects of health insurance: an opportunity, and a problem.

The opportunity is to reduce administrative costs, as has been said several times today. The New England Journal of Medicine says that administrative costs in health care consumes $96–120 billion a year.

There is a blizzard of paper work. It is a nightmare for patients, for hospitals, for doctors, and for insurance companies.

It just so happens that I have a little sample here of the forms completed by one of my staff members who had a knee injury last year.

This is what she had to fill out. The hospitals, the doctors had to handle it, the insurance companies had to go through it. This is just for one patient, for 1 year for one knee problem.

The CHAIRMAN. I hope you are not asking us to put that in the record. [Laughter.]

Senator BOND. No, sir. As a matter of fact, she asked for it back, because if she has to go back and check, she needs to keep up with it. But, there is, as Senator Daschle described, no question that this is a hassle for the insured.

I think that there is a solution for it. It is one that has been mentioned by everybody else: it is a simple card like the ATM card that we use at banks. According to the estimates from the New England Journal of Medicine, I think perhaps $50–$80 billion a year could be saved on paper work and the system significantly simplified.

Now, I propose we use some of those savings to deal with the real problems that have already been referred to today, and that is the lack of consumer protection in the health insurance system.

I held hearings all over the State of Missouri last week and some of the stories that I was told were almost unbelievable. We met in St. Louis with parents of a child who was born with hydrocephalus, a swelling of the brain. The son is now 14 years old. Nine years ago, the family went bankrupt because they could not keep health insurance and they had to use up all of their assets to pay their son's bill.

Another couple in St. Louis had a terrible problem when, the wife was expecting and the husband was laid off. He got another job, but pre-existing conditions excluded that birth from coverage. Unfortunately, the son was born with a defective heart valve, and they have just run out of the COBRA health insurance protection. They are not going to be covered.

In my home town, a good friend of mine had been getting health insurance through his wife's plan for $172 a month. Last year, he developed cancer. The cancer was treated and seems to be in remission—but then he got his December premium.

They put him in a new tier. Instead of $172 a month, he was going to be paying $930 a month in health insurance premiums. It appears to me that there are companies who think that insurance is to avoid risk rather than to spread it.

Under the qualified plan legislation I will propose, you would have to have electronic billing for the consumers, and I would not limit this to workers small businesses.

I would propose that we guarantee acceptance into a plan; we guarantee renewability; we limit the variation in premiums so you cannot jack it up when somebody gets sick; eliminate the pre-existing condition if you move from one qualified plan to another and limit out-of-pocket costs.

Now, I would propose we create an independent Health Insurance Standards Commission to oversee implementation of the Qualified plans make recommendations to the Secretary for additional standards so you do not get into the UB–82 problem where the government proposed a simplified form, everybody developed their own gewgaws, whistles, and bells, and it became the same blizzard of paper work all over again.

How to get the insurers to do this? This is where I propose to use the stick that has already been developed, and that is a 25 percent excise tax on gross premiums of any insurance plans which do not meet the Consumer Protection standards and do not participate in electronic billing to reduce administrative costs.

Both of these goals—cutting down on paper work and providing consumer protection—I believe are achievable this year, and they would fit whether you go with a pay-or-play proposal or a market based proposal. I think these are some very real problems that can be fixed right now.

Mr. Chairman, I very much appreciate the opportunity to come before you. I can tell you, having talked with health care providers, insurers, consumers, and employers across my State, they may not agree on aspects of health insurance reform, but they do feel that we can limit paper work, get rid of much unneeded expenses, and provide vitally needed consumer protections.

Believe it or not, I have an even longer statement and I would like permission to submit it for the record.

The CHAIRMAN. We will take that in the record.

[The prepared statement of Senator Bond appears in the appendix.]

The CHAIRMAN. Thank you very much, Senator. Our first witness will be——

Senator RIEGLE. Mr. Chairman, would you mind if I just pose one question to Senator Bond before he goes?

The CHAIRMAN. Yes, of course. Go ahead.

Senator RIEGLE. I appreciate it. I was late in arriving, so I was not able to make opening comments.

But I find your suggestions very interesting, and I particularly was struck by the illustrations of case examples of people that you have cited, and think that we have all had that happen.

I have certainly encountered that in Michigan where we have people in every circumstance who need health care, are not getting it, cannot afford insurance, lose their insurance, or get jacked up to a higher rate.

Should I draw from your testimony that you also feel that we ought to move now on a comprehensive national insurance plan of some sort that covers everybody?

Senator BOND. I think that we need to have universal access. I do not know whether we would agree on the precise type of approach.

Personally, I think we need to do a lot more just on the access side to make sure that we get health care available in all areas. I am a member of the Rural Health Task Force, you and I have talked about other areas of coverage.

Senator RIEGLE. Right.

Senator BOND. I note, particularly, Senator Moynihan, who stated early on, that we caused the homeless problem when we shut down mental hospitals and found that the system was not adequate. There are many additional problems.

I personally favor using the market-based approach to the greatest extent we can, but whatever way you go, I think that the computerized universal filing can save significant dollars, and, to the extent that we have private health insurance involved, as I believe we must, in my view, whether it is pay-or-play, or anything else, that you need these consumer protections.

Senator RIEGLE. Well, I am with you on that. I just want to understand whether you support—because you have spent a lot of time thinking about it—universal access, where everybody gets covered one way or another so it is not just the case of the lucky person on the block who has the cancer—no one is lucky with cancer, but the person has the insurance—and the next-door-neighbor has cancer and has no insurance. So, you are with us on universal access, I take it.

Senator BOND. We provide access, we provide payments through Medicaid and others. There may be wealthy people who do not need health insurance, they want to pay it out of their pocket.

Senator RIEGLE. Yes. But I am talking about access that gives coverage. I think everybody in the country ought to have access and coverage with health insurance.

Senator BOND. This would guarantee acceptance. If you wanted health insurance, you could not be denied because you were sick.

Senator RIEGLE. Well, but you could be denied because you didn't have the money to pay for it.

Senator BOND. No. The President has submitted proposals for tax credits and assistance for low income persons who are not on Medicaid. I think that ultimately some kind of system like that would be a better way to go. But that is beside the point.

If you require everybody to have insurance, as some small business groups have suggested; or if you require all employers to have insurance; whatever way you go, these proposals, I think, would fit with the measure that you are considering today.

Senator RIEGLE. Well, I do not want to take any more time except to say I think there are two things that we have to agree on, and I think if we are going to get anything done, we are going to need your help. One is, you have got to cover everybody. I mean, we have got to have a plan that covers everybody in the country, and not with gimmicks.

I mean, it is one thing to say people get tax credits; but they may not have the money to buy the insurance in the first instance. Unless the government is going to give them a check, they are not going to be able to have it.

And the other is cost controls. If we do not have a system of really containing the growth in cost along with the coverage, we are, I am afraid, spinning our wheels. And I would hope that on those two issues if we could agree on those principles, then I think we can work out the details. Can you sign on for those, too?

Senator BOND. Will you sign on medical malpractice reform and all those things?

Senator RIEGLE. Yes. Yes. Absolutely.

Senator BOND. I believe that we will come to agreements on the broader plans. What I am saying today is I believe the Chairman wants to move on some very, very important reforms that will have an impact today as we work on the broader problem. I would hope that we could include these consumer protections. We will discuss at length the broader and very diverse questions in health care coverage.

The CHAIRMAN. Thank you, gentlemen.

Senator RIEGLE. I hope that means yes.

The CHAIRMAN. Thank you, gentlemen.

Our next witness will be Mr. Earl Pomeroy, who is Commissioner of Insurance for the State of North Dakota, and he will be appearing on behalf of the National Association of Insurance Commissioners. We are very pleased to have you.

**STATEMENT OF EARL R. POMEROY, COMMISSIONER OF INSURANCE, STATE OF NORTH DAKOTA, BISMARCK, ND, ON BEHALF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS**

Mr. POMEROY. Thank you, Mr. Chairman. My name is Earl Pomeroy, Commissioner of Insurance for North Dakota. I am testifying this morning, on behalf of the National Association of Insurance Commissioners. With me is Gary Claxton, of our Washington office.

The soaring costs of medical services are presently threatening the very viability of our private insurance system. At its root, the concept of insurance depends upon the premiums of the many to pay the claims of the few. In light of unrelenting increases in both the cost and utilization of medical services, the premiums now required to cover claims are becoming unaffordable to much of the market.

In the small employer market, insurers responded to the affordability crisis by engaging in practices designed to limit the claims costs to be spread across all of their insureds.

These practices included screening out individuals and groups more likely to have medical claims and premium rating schemes, which focused high costs on particular groups. These practices have accelerated as cost increases continue to threaten basic affordability.

The result is a small group health insurance market which no longer assures coverage for those who need it, or any reasonable premium stability for employers struggling to keep an employee benefit package in place.

Reforms are needed, and needed now to prohibit the unrestrained fragmentation of the small employer group market. We need to reimpose on the insurance industry the fundamental con-

cept of insurance itself—broad-based risk pooling—in order to improve stability of this most volatile segment of the health insurance market.

As an organization of State Insurance Commissioners, we have developed a recommended package of small group health insurance reforms for States to enact. Our reforms closely parallel many of the provisions of S. 1872. Clearly, we see this situation similarly.

The goals of our reforms have been to guarantee access to coverage, regardless of the health status of a group's employees; severely restrict an insurance company's ability to cancel or nonrenew coverage; address the sorry phenomenon of job-lock by eliminating pre-existing condition limitations and guaranteeing access to group coverage for persons switching jobs; prohibit abusive rating practices by limiting an insurer's ability to use experience, health status, and duration of coverage as factors determining rates and rate increases; and, finally, require actuarial pricing and improved disclosure of rating schemes to purchasers.

I would caution this committee to keep in mind that the effect of reforms like those contained in the NAIC package, or those contained in S. 1872, will drive up costs for a significant part of the market. Insurers will be prevented from avoiding poor risks, and will be restricted from isolating the additional claims for the groups responsible.

Fairness and sound public policy require that these steps be taken, but the results will cause premium hikes for many small employers who benefit from current practices. The more stringent the reforms enacted, the tougher the resulting premium shock will be to the market.

In developing our reforms, we established broader risk-pooling, while attempting to minimize market disruption. The rate bands we allow are not magical and will be monitored as to their effectiveness. I am inclined to see them as a first step to further reforms which will be phased in over time.

There are many concepts in the bill before you that we can support. Perhaps most fundamentally, however, the bill enlists the expertise and resources of State Insurance Regulators in designing and implementing the reforms. We believe that preserving a significant State role is crucial to achieving a program with maximum effectiveness.

We look forward to working with this committee as we mutually address this issue of critical public concern.

Mr. Chairman, I would be happy to answer any questions you or the other members may have.

[The prepared statement of Mr. Pomeroy appears in the appendix.]

The CHAIRMAN. Mr. Pomeroy, this is obviously an extremely complex subject.

Commissioner POMEROY. Yes.

The CHAIRMAN. And one of the things that concerns me is the impact of community rating. I have sympathy with the concept of community rating. And that is especially true with respect to the difference in rates between men and women.

I have concerns about the impact of community rating on the price of insurance for those small employers who benefit from the

current practices of insurers, such as those with younger employers. You have commented on it, and some of the others have.

There are members here that would prefer that I go much further than I have in this respect, but I have concern about not having enough good information about the impact of the subsidies under community rating on premiums for some of the smaller employers. What can you give me on that? I would like to have you further develop that.

Mr. POMEROY. Mr. Chairman, our own information is somewhat sketchy as well. States have only recently begun enacting the limitations I have already spoken of, however, we do have some estimates. The guaranteed access component of our reforms, we estimate, will add between 5 to 10 percent to the cost of premiums spread over the entire small employer group market insuring with private carriers.

The range of impact also depends on the group; the healthier groups that get the benefit of current rating practices may have additional premium increases of 5 to 20 percent.

Younger, healthier groups; receive the most advantage of lower rates under the present rating schemes and will experience the most dramatic impact from the reforms.

We estimate an additional rating impact even higher than 20 percent could be experienced under a full community rating plan. Premium rate shock of up to 100 percent, in my opinion, would not be uncommon, depending on the employer group involved.

The CHAIRMAN. Senator Packwood.

Senator PACKWOOD. I have no questions, Mr. Chairman.

The CHAIRMAN. Are there other questions for Mr. Pomeroy?

Senator BREAUX. Mr. Chairman.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. I just have one question. Apparently it seems that NAIC has no position on the Federal role in the health insurance plans or the reform effort.

I am just trying to figure out, what you think. I mean, do we do it on a piecemeal basis, each of the 50 States move in the direction of adopting a model law that they would see fit, or what is your feeling is an appropriate and proper Federal role for establishing some kind of a national framework?

Mr. POMEROY. Well, Senator Breaux, we certainly recognize that problems in the health insurance market generally, in the small employer market particularly, are now of a level of pressing national concern.

Our organization has yet to take a formal position on any of the Federal proposals, and so I am without authority, speaking on behalf of the association, to advance support for an explicit Federal role. But we do recognize there is a national interest involved.

Senator BREAUX. Thank you.

The CHAIRMAN. Other questions?

Senator ROCKEFELLER. Mr. Chairman.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Mr. Chairman, in fact, I think you want us to proceed, so I will not ask a question. I want to be able, though, to send, and put Mr. Pomeroy on notice, a number of ques-

tions, particularly with this whole question of the NAIC rating reforms and the bands and geographics; that kind of thing.

Mr. POMEROY. We would be happy to provide such further information as we might.

Senator ROCKEFELLER. Thank you.

[The questions appear in the appendix.]

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. Mr. Pomeroy, I am just a little bit concerned about the resources the States do or do not have to adequately protect consumers with the regulated insurance industry. I know, at least in my State of Montana, the Insurance Commissioner's office is being cut back, there are fewer employees; resources are diminishing.

Just give me a general sense of the degree to which you think States have the resources and/or the power to implement the changes that we are all talking about in a meaningful way.

Mr. POMEROY. Senator Baucus, the trend nationally is to increase staffing of State insurance departments, even in a time of tough budgets. This has been done by special assessments to the industry itself to pay for more of a regulatory overlay.

The step taken by Montana in actually reducing its staffing in the department is out of sync with the norm in that regard.

I think that States, particularly in the manner described within the Bentsen bill, do have a capacity to participate in a very meaningful way, and, in fact, have hands-on resources, expertise, and daily involvement with the market that really compels our involvement in any reform effort.

We are limited more as a result of limits on our jurisdiction, however, particularly in the health insurance marketplace. We will have full regulatory authority over the private insurance market; none over the self-insurance market.

Unfortunately, employers and employees really do not understand the difference. They do not understand when they are getting jacked around on a claim that we can help one group; we cannot help the other group at all. Accordingly, I think the ERISA exemption created an inequity of recourse to the consumer with a health insurance problem.

Senator BREAUX. And how much will this bill address that?

Mr. POMEROY. The bill does not address it in a comprehensive form. It does impose the provision of the job-lock component—the pre-existing condition prohibition—on insured groups and ERISA plans alike.

Senator BREAUX. Thank you.

The CHAIRMAN. Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman. Mr. Pomeroy, S. 1872 assigns certain responsibilities to the National Association of Insurance Commissioners, among which include the development of specific standards for the implementation of the requirements of Part B of Title II. Now, what aspects of these responsibilities do you find most troublesome?

Mr. POMEROY. Senator Hatch, we can undertake the responsibilities allocated in the bill. The most troubling feature of the bill, in my opinion, is imposing a uniform type of benefit package all over the country. The markets across the States differ dramatically.

I think the NAIC approach is one which recognizes greater flexibility between States and gives States more authority to address their own unique marketplaces as they see fit. That is, perhaps, our biggest point of reservation about the bill before you.

Senator HATCH. All right. Is the timetable realistic for the NAIC to accomplish the responsibilities proposed for the NAIC in this legislation?

Mr. POMEROY. Senator Hatch, much of the task which would be assigned we have already undertaken on our own. That is a realistic timetable.

Senator HATCH. So it is realistic. All right. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Bradley.

Senator BRADLEY. Thank you very much, Mr. Chairman. Given the rating bands in the bill, what would be the maximum difference between the highest and lowest cost premiums an insurance company could offer a small business?

Mr. POMEROY. Under the NAIC proposal, we allow rates to differ as much as 200 percent. The highest rate can be virtually double that of the new business rate, the lowest rate offered.

Under Senator Bentsen's bill, or S. 1872, initially the rate cap is 1.8, and, after 3 years, 1.62. Therefore, as opposed to 200 percent allowed by the NAIC model, 162 percent would be the maximum spread. And so, it is a tighter rate band.

Senator BRADLEY. Yes.

Mr. POMEROY. Again, we do not find anything magical about the bands that we have constructed. The tighter you make the band, the more cross-subsidy you enforce.

Senator BRADLEY. What do you see as advantages or disadvantages of a pure community rating?

Mr. POMEROY. Well, the advantages, Senator Bradley, are that everyone pays the same; you have maximum cross support for the claims; you have got maximum cross subsidy occurring within the insurance program.

The disadvantage is what I call premium shock: dramatic rate hits to those that are presenting benefitting from existing rating schemes. The marketplace generally has moved away from community rating many years ago, and it would be rather tough medicine, I think, to go back without a transition period.

Senator BRADLEY. And who would be hit the hardest?

Mr. POMEROY. The groups that would be hit the hardest are the groups that presently benefit from experience rating plans, particularly groups with younger, healthier workers, and better claims experience.

Senator BRADLEY. So, they would pay more, and the older would pay less.

Mr. POMEROY. They would pay much more. And those that are particularly surcharged or isolated for claims payments would pay less.

Senator BRADLEY. Overall costs?

Mr. POMEROY. Overall, I believe most of the market would pay more and a smaller portion of the market would pay less.

Senator BRADLEY. So, total costs would go up?

Mr. POMEROY. No, the total cost would be effectively the same, it is just how you are shifting them around. Another component of both the bill before you and the NAIC proposal is the increased access feature. Now, that brings into the system people that are excluded presently, and that does add an additional cost of estimated between 5 and 10 percent.

The CHAIRMAN. Senator Riegle.

Senator RIEGLE. Thank you, Mr. Chairman. I am an original cosponsor of this legislation of Senator Bentsen's, and it certainly moves in a constructive direction.

I want to draw attention to the first paragraph of your statement here today after you identify yourself in your prepared statement.

This is what you say: "Perhaps the most important public policy issue for State and Federal officials is the tragic fact that over 34 million men, women, and children have no health insurance—have no health insurance—and, therefore, have severely limited access to health care itself."

And then you say, "The core problem underlying this tragedy is the seemingly intractible issue of soaring health care casts.

The rapid, unrelenting increases in health care costs are placing a tremendous strain on health care financing and delivery systems in this country, both public and private.

Now, you are here representing all of the State insurance officials across the country, so you are here representing not just your State, but, in effect, 50 States.

And, in the first policy words out of your mouth today in your statement, you are saying we have got 34 million people with no coverage, and you have got costs out of control in the system—soaring, to use your words—which are, in effect, beginning to cripple the whole system.

Do we not have to solve those two issues? I mean, if we do not solve the coverage and the access issue so that everybody is covered in America, and, at the same time, have a meaningful cost control system and strategy, I mean, we are not really dealing with our problems, are we?

Mr. POMEROY. Senator Riegle, that is correct. We agree with that. I think that insurance regulators, although it goes beyond their jurisdiction, believe that it is not acceptable for this country to have 34 million uninsured.

And we believe that the system has been brought to the point of crisis because of its inability to contain medical cost inflation. And without significant emphasis, particularly on cost inflation, any measures such as the bill before you will only be an interim step. The system will break apart and require much further work.

Senator RIEGLE. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Mr. Chairman, I was trying to set a pattern of not asking questions, and I failed. [Laughter.]

Senator ROCKEFELLER. So, I have to, plus the fact that I think Mr. Pomeroy misspoke on something in response to Senator Bradley, which needs to be on the record.

When you were referring to the rating bands and the adjustments in responding to Senator Bradley, I think you said 1.62, you

were only referring, however, to health status, were you not? You were not referring to age or sex.

Mr. POMEROY. Correct. Correct.

Senator ROCKEFELLER. Well, you should have said that.

Mr. POMEROY. I beg your pardon. I stand corrected, and I certainly did not mean to mislead the Senator. We were talking about bands imposed on experience rating. I was not addressing the traditionally-imposed demographic rating characteristics.

Senator ROCKEFELLER. And then, Mr. Chairman, with your forbearance. Mr. Pomeroy, under the NAIC rating reforms there are no limits on adjustments that could be made for demographics, such as age or sex. Am I correct?

Mr. POMEROY. Senator, that is not quite correct. We do require that they be actuarial based, based upon sound actuarial principles. So that gender-based rating factors have to be borne out by claims experience.

Senator ROCKEFELLER. All right. I need to get an answer on a small business situation. The Congressional Research Service has found a very prominent commercial carrier here in the D.C. area whose age and sex rate adjustments range from .58 to 1.81, which is a ratio of about 3:1. Do those adjustments seems plausible?

Mr. POMEROY. Senator Rockefeller, they seem very disturbingly high to me, but I am not an actuary and do not know the basis for that distinction.

Senator ROCKEFELLER. Yes. If we use the CRS example the law of averages tells us that these adjustments probably will not matter a great deal to large industries because they are going to have older, younger, healthier, less healthy—they are going to have an average demographic group.

A small employer, though, especially one with fewer than ten in the group, is most likely to have a skewed demographic range, at least it makes sense. Let us say that if it was a group of four, there might be three 55-year-olds. You understand the question I am making.

Mr. POMEROY. Yes.

Senator ROCKEFELLER. Now, under that CRS example, again, the older group in a small setting would pay three times more than the younger group just based on age and on gender. My question is, how do you expect, with the proposal that you are putting forward, small business to be able to handle this financially?

Mr. POMEROY. Senator Rockefeller, we believe that our rating bands are an interim step. Conceptually we do not take issue with the equity basis for pure community rating, including demographics.

But, under the example you suggest, moving quickly to pure community rating would impact a small employer group filled with younger workers 300 percent.

And we believe that would have an extremely disruptive impact on the market, potentially making the uninsured situation worse rather than better.

Senator ROCKEFELLER. So that in either event it is going to be disruptive. The question is, one is disruptive in the temporary and the other would be disruptive in the getting to it, but not disruptive after settled into.

Mr. POMEROY. Senator Rockefeller, I think less disruptive if phased in gradually. You let business budgets adjust and business planning move forward. To hit the market in one fell swoop with something like this, I believe, would cause a very adverse public reaction.

[Clarification of testimony follows:]

CLARIFICATION OF TESTIMONY

In response to a question from Senator Rockefeller regarding differences in premium attributable to adjustments for age and gender, I indicated that a ratio of 3:1 for such adjustments seemed "disturbingly high." In fact, as we have informed the Committee since the hearing, age variations in this range are not uncommon. Adjustments for age and gender can produce variations of more than 3:1, and the premium rates charged for employees between ages 60 and 65 often vary from the premium rates charged for employees below age 30 by 4:1 or 5:1.

I hope that this statement will correct my earlier misstatement. I regret any confusion I inadvertently may have caused and thank Senator Rockefeller for helping to set the record straight.

Senator ROCKEFELLER. Yes. Thank you, Mr. Chairman. Thank you, Mr. Pomeroy.

Senator DURENBERGER. Mr. Chairman.

The CHAIRMAN. Yes, Senator Durenberger.

Senator DURENBERGER. I think we are all taking a little more time with Mr. Pomeroy today because he has been here before and we have dealt with these issues, and he represents at least the regulatory part of the problem.

In just listening to my colleagues' questions, it really is important to point out to everybody in this room, I think, that everyone here says that the costs are the big problem in health care, and everybody agrees on that. And the origin of the cost problem really starts with insurance.

I mean, insurance became an insulator between buyers and sellers in this great market of ours. All you had to do was send your bill to the insurance company; whether you are the doctor or you are the consumer, just send the bill to the insurance company. That is why we have an $821 billion problem in America today.

Now, what has State regulation given us? They have given us the opportunity to experience rate, move away from community rating, move away from everybody paying approximately the same price for the same product in the same community to go to experience rating, where you could go to the healthy, you could go to the young, and you could cut the price in half, and you could ruin the function of insurance in this whole marketplace.

Now, I am not against State regulation of insurance. My particular proposal said we ought to go farther than the one I am now the chief co-sponsor on.

But we have to deal with the reality that this is one Nation with a big problem and the Federal role in regulating what is not just insurance—it is a whole lot more than insurance that we are talking about here today—becomes critical.

Now, the questions that you were asked relative to community rating are very important questions because the first backlash—and I am sure we are going to get it, Mr. Chairman, within a week—is going to be from all of the fire and casualty and homeowners people who do not want to get out of health insurance be-

cause they are in and out of this system every year making money on it.

They do not want to get out of this business. They do not like the notion that some of us are standing up here saying, 1,500 companies is too many; we ought to get it down to 50, or something like that. Then we might get something realistic without having to go to Canada, or without having to go to State sponsors, or something like that.

So, the backlash from half the people in this room after this hearing is going to be, all the rates are going up, all the young are going to pay more.

Now, the reality is, I presume, if you have 200,000 employees in a group, you are very close to community rating. If you are buying your product from somebody who can spread their risks over five million participants in the program, the young are paying for the old, and the healthy are paying for the sick in those large groups already.

So, of course, in this small market where it has been experience-rated for 25 years, the healthy are going to pay more if you move in this direction.

And I am laying this out not as a fiat, but as part of a premise of a question to ask you, because the difficult problem with which we are going to be challenged here in the next week or so is, what are we going to do about re-insurance, risk-pooling; those kinds of issues.

In my State, or in many of the States here, in order to do a fair job on insurance reform, someone is going to have to bring the so-called self-insureds in all of our States somehow, somewhere, into the insurance reform game.

And, traditionally, big businesses and the self-insureds have opposed the changes in ERISA preemption. I have opposed changes in the ERISA preemption, but I know what is going on in my State.

When my State passed the small group insurance reform, they are also going to try to pass a provider tax; put a tax on all the hospital bills, all the doctor bills; all that sort of thing, and then put that into insurance reform just to get at the self-insureds. That does not make a lot of sense to me, to recycle that money.

So, I am really concerned about how you view, from the State Commissioner's perspective, the problem of how do we build re-insurance in here; how do we build in the risk-pooling now that we have said guaranteed issue, guaranteed renewability, limiting pre-existing condition; how are we going to deal with those particular problems?

Mr. POMEROY. Senator Durenberger, you raise a very important point. The ability of State Insurance Regulators to comprehensively address the small group market has been limited by the ERISA pre-emption. We can only impose costs through the regulatory mechanism on the privately insured groups.

The most costs we impose—for example, the cost of guaranteed access—fall on those employers that privately insure, not those that self-insure.

The result, therefore, of health reforms has fallen disproportionately on small employers not able to enjoy the ERISA preemption through self-insurance.

I believe that the reforms the NAIC has advanced which place costs on the private sector are probably not going to break the private sector. We have been measured in the reforms we have move forward to date.

I look, though, at this committee's approach, and would encourage you to assess those costs over the marketplace just as broadly as you possibly can.

Senator DURENBERGER. All right. Thank you.

The CHAIRMAN. Thank you. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Mr. Pomeroy, I have legislation S. 1936 which 22 members of the Senate Republican Task Force have signed dealing with insurance market reform and small group insurers. That applies to businesses with between two and 50 employees. The Chairman's bill is very similar to mine.

But then we wonder whether that is the right number, and that is what you have talked about. Should it be one to 100, or is two to 50 enough? Do you have any thoughts on that?

Mr. POMEROY. Senator Chafee, our own proposals go two to 25, and so we draw the number for small group where it has traditionally been placed, at about the 25 lives, and do not go up to 50.

Again, there is nothing magical in our cut off point. The small employer market represented in the 25 to 50 lives, I believe, has functioned much better than the small end of the segment.

I believe the insurance community would tell you that you are risking imposing substantial disruption into a component of the market that is working relatively well and would prefer, therefore, limiting these reforms to the 25 lives and under.

Senator CHAFEE. You think—just take the 50. Do you think businesses with above 50 employees can bargain successfully with the insurance companies?

Mr. POMEROY. Many of the dynamics that plague, in particular, the small employer group begin to fade as you get over 50.

Senator CHAFEE. So, you would suggest sticking at the 50, certainly since you only go to 25.

Mr. POMEROY. The answer to that, Senator Chafee, is yes. The membership that I represent this morning actually has drawn the line at 25.

Senator CHAFEE. Let me ask you another question, and this gets back to the question the Chairman asked previously about the community rating.

And it seems to me that, as you have heard from this group up here today, one of our great concerns is controlling the costs. And unless we can control these costs, we cannot get to first base.

Under community rating, you would give no break, as it were, for those companies who made an extra effort to keep their people healthy. And it does not necessarily mean you have to be young.

For example, in my State, some companies have gone to a nonsmoking policy. And if they have got an inveterate smoker in the company, they send him to hypnotists and everything else. I do not know whether they have achieved a 100 percent elimination of smoking, but they have come very close to it.

Now, presumably, one of the rewards—and that is not the reason they are doing it—might well be that they would have lower insur-

ance rates. Yet, on the community rating, that would not be permitted. Is that good?

Mr. POMEROY. Senator Chafee, no. I think employers should have an incentive to work on healthy lifestyles of their employees for purposes of improving claims experience.

On the other hand, the experience rating hitting small employers today really does not have any relation to an employer's ability to move forward risk containment measures.

In other words, I think that employers should have an incentive to encourage wellness in their work force, but I do not think that there is an actuarial justification to have particularly significant rate differentials based upon claims experience.

Senator CHAFEE. Well, all through these various measures that have been presented there is a thrust toward preventive medicine, i.e., keeping the public healthier.

Yet, under the way you envision it, certainly with the community rating, and, indeed, what we have got, that would not be rewarded, apparently, for the small employers.

Mr. POMEROY. Well, Senator Chafee, the Insurance Regulators' bill does not go toward community rating. Certainly there is tolerance within our rate bands to recognize an employer's incentive program to encourage wellness.

Senator CHAFEE. All right. Fine. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. There are no further questions. Thank you very much, Mr. Commissioner.

Our next panel will consist of: Kay Johnson, the Senior Policy Advisor for the March of Dimes; Mildred McCauley, a Member of the Board of Directors of the American Association of Retired Persons from Myrtle Creek, Oregon; Judy Waxman, Director of Government Affairs, for Families USA; Washington, D.C.; Dr. Bryant Welch, Executive Director, Practice Directorate of the American Psychological Association in Washington, D.C. We are pleased to have you.

Ms. Johnson, if you would proceed, please.

## STATEMENT OF KAY A. JOHNSON, SENIOR POLICY ADVISOR, MARCH OF DIMES, WASHINGTON, DC

Ms. JOHNSON. Chairman Bentsen and members of the committee, on behalf of the March of Dimes Birth Defects Foundation, I would like to thank you for the opportunity to appear before you today. I would also like to commend you for your continued interest in the pressing problems of health care financing.

The March of Dimes shares the concerns of other organizations about the growing cost of health care and about the number of uninsured Americans. Our mission is to improve the health of babies by preventing birth defects and infant mortality. Thus, we have a special interest in the barriers that are faced by millions of families who want to have healthy babies.

We have submitted written remarks for the record, and, in the interest of time, I would like to just summarize my statement.

The CHAIRMAN. That will be fine.

Ms. JOHNSON. As the number of uninsured Americans has grown in recent years, women of childbearing age and children have felt a disproportionate impact.

We look at several facts that are clear indicators of that problem. We know that in 1990 there were an estimated 443,000 pregnant women who had no health insurance; that over 8.4 million women of childbearing age who had no health insurance, and six million of those were working women; that the majority of the uninsured live in two-parent, working families with children; and that the typical woman who is likely to have a baby today is in her 20's, is married, has a family income of just under $20,000 a year, at least a high school education, and either works or lives with a husband who works full- or part-time. Such a family is struggling with the cost of having a baby.

We also know that in small businesses, those with employees of 25 of fewer, only 20 percent of women workers have employer-based health insurance as compared to 60 percent of those in large firms.

We know that the concept of insurance is eroding, that many of the sickest populations have been left behind, and that preventive medicine is not a part of plans.

An estimated five million women of childbearing age who have private health insurance do not have coverage for maternity care. This means that every year thousands of women have no coverage for prenatal care, even though they might like to seek it, and that infants who are born with a birth defect or some other condition may be excluded from their families' coverage.

We know the Nation cannot continue on this course. We cannot afford to spend 13 percent or more of our GNP on health care; and we cannot afford the loss of these children.

The debate on health care reform is gaining momentum and it will clearly show the strengths and weaknesses of various approaches as we move ahead.

But we are trying to push ahead and encourage you in your debate by supporting five principles. First: any health care reform proposal should ensure that all children and pregnant women have coverage.

Second: insurance reform is a start, but it is not going to solve the problems of the distribution, the content, or the appropriateness of services.

Third: a plan should have comprehensive benefits with emphasis on prevention.

Fourth: cost containment must be a priority, and strategies to better manage costs include emphasis on preventive services and prevention research.

And, fifth: a health care reform plan must not only focus on medical care; health research is critical to the development of improved outcomes.

We urge enactment of significant health care reform this year. In an incremental approach, such as that taken in S. 1872, we support the following: standard or comprehensive benefits that emphasize prevention, specifically benefit packages that include comprehensive maternity benefits and comprehensive well-child care.

We support mechanisms to ensure the quality of managed care plans. The certification of plans and other quality assurance mechanisms are essential to the protection of consumers in managed care, and we urge you to act in that area.

We also support efforts to eliminate pre-existing condition exclusions. Pregnant women should not be subject to job lock for fear they will be unable to transfer their maternity coverage, and infants born with birth defects and other special health care needs should be covered. The insurance industry should not be permitted to skim the top for the cream of our Nation's crop of children.

We support funding for prevention and outcomes research. Health services research to identify possible new treatments in determining the effectiveness of preventive interventions are essential to cost management in today's market.

And, finally, we support reforms to increase health care coverage among workers in small businesses. We know that today employment in small business translates into inadequate insurance for families and children, most often for pregnant women.

Moreover, protecting the health of pregnant women is a societal responsibility. Therefore, we urge the committee to avoid any rating approach that would isolate pregnant women away from families in the broader system.

We urge you to act thoughtfully and expeditiously to ensure access to care for all Americans. And, as you move forward, we hope you will put pregnant women and children into the lifeboat first. Thank you.

[The prepared statement of Ms. Johnson appears in the appendix.]

The CHAIRMAN. Thank you very much, Ms. Johnson. I must say, you have an in-house lobbyist in my home with my son on your national board. [Laughter.]

Ms. JOHNSON. We appreciate all the work he does for us as a volunteer.

The CHAIRMAN. And my wife is also involves with the March of Dimes. So, I am overwhelmed by your argument. [Laughter.]

The CHAIRMAN. Ms. McCauley, we are pleased to have you. Ms. McCauley is a member of the board of directors of the American Association of Retired Persons.

**STATEMENT OF MILDRED McCAULEY, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, MYRTLE CREEK, OR**

Ms. MCCAULEY. Thank you, Mr. Chairman. I am Mildred McCauley, of Myrtle Creek, OR, and I am a member of the board of directors for the American Association of Retired Persons.

Thank you for the opportunity to testify on some of the immediate steps that the committee is considering to begin to address the very thorny topic of reforming our health care system.

While my testimony today focuses on the need for expanded Medicare coverage of preventive care, I want to preface it by saying that AARP believes firmly that comprehensive reform of our Nation's health care system is our number one priority.

The Medicare expansions and the insurance market reforms included in your bill are steps in the right direction. But each of

these steps must be a part of a larger strategy to reduce the growth in health care costs and provide access to health and long-term care for individuals of all ages.

Further, AARP believes that any incremental steps, such as the insurance reforms included in your bill, must provide real benefits to consumers. We also believe that insurance market reforms should include provisions to protect purchasers of long-term care insurance.

My written statement explores this particular issue further. AARP would be pleased to work with the committee on an insurance reform package that complements broader health care reform.

I will turn now to the issue of preventive health care. As a survivor of breast cancer, I know first-hand that preventive health care not only saves the expense of more costly treatment, it also saves lives.

Unfortunately, early detection is often not an option for millions of older Americans. Medicare's coverage of preventive care is minimal at best, and the high cost of health care has created an even greater barrier to these services.

Medicare coverage of additional preventive care service would make these services more affordable, help to avoid greater costs that occur when the early warning system of preventive care is not available, and saves lives.

S. 1872 takes major steps in this direction by expanding Medicare to include coverage of annual mammograms, colo-rectal cancer screening, flu vaccines, and well-child care for children suffering from end-stage renal disease who are Medicare beneficiaries. It also establishes demonstration projects that could lead the way to Medicare coverage of additional preventive benefits, including comprehensive assessments for older beneficiaries, which AARP views as the foundation for maintaining good health.

S. 1872 proposes no method of financing the new and expanded preventive benefits. Considering the current budget rules, this raises some concerns.

AARP views the traditional financing of Part B, which spreads the program's cost across the entire population, as the most appropriate financing structure for new Medicare benefits.

In conclusion, let me say that AARP applauds your efforts to close some of the existing gaps in the Medicare program by expanding coverage for preventive health care. This is an important incremental step towards broadening access.

AARP maintains, however, that each incremental step should move us closer to the overall goal of comprehensive health care reform.

We recognize that broad public consensus will be key to achieving a health care system that provides access to both medical and long-term care for all individuals.

The public needs to understand that there are choices and tradeoffs associated with reforming the health care system. That is why continued public education is essential.

Clearly, the association cannot build a broad public consensus on its own. It is incumbent upon the administration and bipartisan Congress, as well as AARP and other groups, to lay the ground

work that will focus public attention on the tough choices that must be a part of the solution.

The 1992 elections will offer an important opportunity to help inform the public about the choices and the costs of reforming our health care system.

AARP, through the efforts of our volunteer leaders around the country, is working to ensure that the 1992 elections are a forum for national debate on health care reform.

Mr. Chairman, thank you for the opportunity to testify today. AARP looks forward to working with you and this committee to make health care reform a reality.

The CHAIRMAN. Thank you, Ms. McCauley.

[The prepared statement of Ms. McCauley appears in the appendix.]

The CHAIRMAN. Our next witness will be Judy Waxman, director of government affairs, Families USA.

**STATEMENT OF JUDY WAXMAN, DIRECTOR OF GOVERNMENT AFFAIRS, FAMILIES USA, WASHINGTON, DC**

Ms. WAXMAN. Thank you very much, Mr. Chairman, for asking me to testify today.

I appreciate the acknowledgement from you, the other members of the committee, and other people on my panel, that there is the need for comprehensive reform. Only when we have control of the costs in our system system-wide and everyone has insurance will the problem be solved.

A second caution I have is on the small group insurance market reform. It may be that some of the people we are trying to help will not be helped by this legislation.

In particular, as was already mentioned, some of the reforms, such as including everyone in the plans—everyone that has a preexisting condition, which, of course, we think is a wonderful change—will, indeed, add some costs to the system.

That is another reason to support control of the entire system, that is underlying health care inflation. Rising costs is the real problem. It puts insurance out of reach for many small businesses.

On the continuity and availability of coverage, we do think that these changes are extremely important and worthwhile.

And, therefore, in addition to the groups that you cover in the bill, we think that these protections should be extended to the most vulnerable group in the health insurance market: those who have individual coverage.

It is not really reasonable or fair for an individual who leaves a group plan and goes into the individual market to then be subject to new waiting periods, even when they were, indeed, continuously covered.

On the rating practices, increasingly it is true that hiring decisions must take into account the gender, age, and health status of potential employees and their families because of the way that insurance rating premiums are designed today.

Your bill does propose some limitations for groups of two to 50—and, I might add, President Bush's plan actually covers groups of one to 100 on this issue—and does leave unlimited rate adjustments for age and gender composition of the group.

We think these limits are simply too broad. The proposed rate bands will leave small employers with significant financial incentives to avoid hiring women, older workers, and disabled people.

As to the sticker shock that was mentioned earlier, even under our current practices, it is true that a young, healthy group today does get older and sicker every year. And, in fact, moving towards community rates may benefit that very group, as well as the other groups.

On benefits, we support the standard benefit package that is in S. 1872, and, I might add, with the addition of some crucial services: prescription drugs, family planning services, and some smaller cost-sharing requirements.

Many of you may be aware that last spring we issued a report called "Barebones Coverage Insurance That Does Not Insure." We concluded that bare bones coverage—that is, very limited benefit packages that some States are now designing—provides inadequate coverage, and, indeed, it is not attractive to many employers. I think that the basic benefit plan in S. 1872 could be called bare bones.

What many of these limited benefit packages actually do is reduce premiums by raising the cost sharing, which really does not save money to the individual, it only shifts health costs from premium payments into the out-of-pocket payment category.

On the issue of deductibility for individuals, we think that full deductibility for individual policyholders does establish equity between the subsidy received by businesses and individuals.

But, as a caution, I might add that because the pre-existing condition limits do not apply to this population, nor the rating requirements under this bill it may mean that the insurance is still unaffordable for those individual buyers.

Lastly, on the Medicare improvements, yes, the preventive services proposed for Medicare beneficiaries are an extremely welcome addition. But I feel compelled to point out, again, what seniors really want and need is long-term care.

Given the severe limitations of Medicare and covering long-term care and the lack of private insurance coverage in this area, it is important that long-term care coverage, including reform of the insurance market for long-term care policies, be included in your deliberations.

In conclusion, comprehensive reform, including systematic cost containment is the only alternative to solving our health care crisis. Small steps cannot guarantee that insurance will be more accessible to small businesses.

Positive improvements in this bill would include extending the continuity of coverage protections to the individual market, eliminating discriminatory practices in setting premium rates, a comprehensive benefits package, and addressing the issue of long-term care. Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. Waxman appears in the appendix.]

The CHAIRMAN. Dr. Welch.

**STATEMENT OF BRYANT L. WELCH, Ph.D., J.D., EXECUTIVE DIRECTOR, PRACTICE DIRECTORATE, AMERICAN PSYCHOLOGICAL ASSOCIATION, WASHINGTON, DC**

Dr. WELCH. Thank you, Mr. Chairman and members of the committee. Good morning. I am Dr. Bryant Welch, executive director for professional practice of the American Psychological Association. I am a board certified Clinical Psychologist and licensed attorney.

Mr. Chairman, I have a one-page executive summary of our written testimony, which I would like to submit for the record, if I may.

The CHAIRMAN. That will be fine.

[The prepared statement of Dr. Welch appears in the appendix.]

Dr. WELCH. The American health care system, as we all know, is plagued by a three-fold crisis. Costs have skyrocketed to the point that 14 percent of our GNP is now spent on health care.

Access to care is diminished to the point that 37 million Americans are with no health insurance at all, and an estimated 100 million Americans are considered to have inadequate health coverage.

Quality of care has suffered greatly at the hands of managed care programs which are given financial incentives to under-treat.

Today you have already heard from consumer groups who poignantly document the enormous life-and-death need for better health coverage.

Shortly, you will be hearing equally sincere lamentations from representatives of small business struggling to survive in a severe economic recession, facing what many feel is unfair foreign competition, and who do not particularly want to take on financial responsibility for a hemorrhaging health care system.

So what can we do? It seems to us that the only hopeful resolution to this dilemma is to acknowledge that we can no longer afford to simply pay lip service to the principles of preventive health care. If we can keep people healthier longer, we have eased the pressure on the health care dollar.

From a psychologist's perspective, Mr. Chairman, there are ample affordable ways to do just that, if we will just readjust our thinking away from an exclusive preoccupation with late-stage physical diseases and focus on early-stage problems which lead to those diseases.

One major, but oftentimes unrecognized reason for the ever-increasing cost of health care in this country are the untreated and inappropriately treated mental health problems of our country.

Estimates are that 60 percent of all visits to general physicians are for psychological problems for which there is no organic pathology.

In fact, people with psychological problems make twice as many visits to their primary care physicians as do people without mental health problems.

Since physicians generally receive only cursory mental health training, these problems often go undetected, and, instead, a myriad of expensive tests and procedures are used with no benefit to the patient, but at enormous expense to the health care system.

Study after study documents that when these patients do receive appropriate mental health care, their medical utilization drops significantly.

But it is not just that people waste time and money; a second and related cost of untreated mental disorders is that they often lead to illness-producing behaviors, again, with enormous cost for the health care system.

Incredibly, seven of the ten leading causes of death and disability are psychologically induced behavioral problems, as are all five of the top reported health problems confronting American business. Alcohol and drug abuse, eating disorders, smoking, obsessive/compulsive behavior, self-inflicted injuries, accidents, child and spouse abuse, and suicide are frequent behavioral concomitants of untreated mental disorders.

These behavioral problems radiate far into the fabric of our society in their vast waste of our Nation's resources. Alcohol and drug abuse alone cost society $143 billion in 1988.

In addition, however, psychological problems are also the direct precipitants of many of these major physical illnesses for which our general medical system also pays a heavy cost.

Indeed, mental health services have been found effective not only in treating, but also in inhibiting stress and anxiety from developing into more expensive physical illnesses, such as ulcers, heart disease, respiratory ailments, and even immune disorders and cancer.

It is important to note that these preventive mental health services are provided almost exclusively in an out-patient setting with minimal financial outlays.

Fourth, and finally, the untreated medical disorders in their own right can reach devastating proportion if not treated at an early stage.

APA believes that the only cost-effective and humane way to resolve the current crisis is through the appropriate use of appropriate preventive mental health care which can reduce the overall demand for services.

The proposed Better Access to Affordable Health Care Act introduced by Senator Bentsen recognizes this principle of prevention through its provision for prenatal and well-baby care.

Its basic plan, however, fails to provide the most far-reaching preventive care currently available in our health care system: mental health services.

A minimal benefit is provided in the standard plan. It is very important to note, Mr. Chairman, that without the minimal coverage in both plans, not only will those who receive coverage under the basic plan be denied access to mental health care, but the problem of adverse selection, which has always plagued mental health coverage, will also drive the cost up.

Of equal concern is the fact that millions of American workers who live in States with mandated mental health benefits, under this plan, will lose the protection of those State laws so the net result will be that millions of American workers will wind up with less mental health care than they have at the present time.

We thank you for this opportunity to testify. We hope that you will amend the bill so that you will have minimal mental health coverage in both your basic and standard plan.

The CHAIRMAN. Doctor, I have demonstrated time and time again my concern for mental health services in legislation in the past, and I still share that concern.

I appreciate your understanding that when the Better Access Bill requires States to develop a basic benefits package, the goal is not to exclude mental health services, but simply to find a package of benefits that is both affordable to small employers and valuable to their employees. So, we need some creative thinking from insurers about how to strike that balance. And I know that is tough.

Now, they have done something recently in Texas, one approach—perhaps you are familiar with it—to provide limited mental health care benefits.

They require that health insurance coverage for State and local government employees include coverage for a specific list of the most severe mental illnesses, such as manic depressive disease and schizophrenia. What is your reaction to that kind of an approach?

Dr. WELCH. Well, we certainly support good coverage for the serious mental illnesses. The insurance problem is just the tip of the iceberg of their problems, and what have you.

But the point I am trying to emphasize, Mr. Chairman, is it is not only the serious mental illnesses that are causing health care cost increases; they are the common, everyday kind of disorders which are extremely disabling: anxiety disorders, depressive illness. Recent studies have indicated that those are every bit as debilitating as chronic pulmonary problems, as cardiovascular problems. So, the cost of these disorders throughout the health care system is overwhelming.

The CHAIRMAN. The problem is the question of cost, and the more benefits we put in—and everybody wants all of them in—the higher the cost. If we are talking about a basic benefit plan, where would you put your priorities in your field of expertise?

Dr. WELCH. Here is what we would do. We have commissioned several studies, which we would be happy to share with you and your staff. The estimates are that it would cost about 2 percent of health care premiums to add an out-patient mental health benefit such as you have in your standard plan. It would cost an additional four percent to have in-patient services.

If we consider that many of these bare bones policies incur about a 40 percent administrative cost, it seems to us that it is awfully hard to justify in that context eliminating the mental health care for all Americans; not just those who are afflicted with certain very serious mental illness, but people whose problems we can interrupt so that it does not lead to long-term health care cost consequences for our system. So, we believe that the research does show that where you structure your benefit appropriately and do not encourage people to use expensive in-patient care, that mental health coverage is very affordable.

The CHAIRMAN. All right, Doctor. Let me get to Ms. Waxman. You talk about community ratings——

Ms. WAXMAN. Yes.

The CHAIRMAN.—and how that would obviously lower the cost for some of the high-risk groups. But it would also, obviously, as has been stated time and time again, increase the premium costs very substantially for the younger, healthier workers.

Are you not concerned that some of the employers then would drop that coverage, thus increasing the number of uninsured? How would you respond to that?

Ms. WAXMAN. I would say this, Senator. Under current practices now, a group that gets insurance for the first time may be a young, healthy group, as you define it. Over the next few years, their premiums go up dramatically anyway. They do get older; they do get sicker. One sick baby in a group such as that makes their insurance totally unaffordable.

So, moving towards community rating can be phased in, I think, as long as that is where we are ultimately going, to subdue some of that so-called sticker shock.

But, also, community rating is a protection for that young, healthy group as well—a protection from anybody getting very sick in the group, and protection for a few years out.

The CHAIRMAN. When you talk to some of the young about a few years out, unfortunately, very often, their eyes glaze over.

Ms. WAXMAN. Well, insurance companies now use durational rating practices where insurance companies decide in advance how much the rates will go up over the next 3 to 5 years—I am not talking about 20 years—this practice currently causes dramatic increases, so that the sticker shock caused by community rating cannot really be judged by looking at 1 year. The increases must be looked at over time.

The CHAIRMAN. Ms. McCauley, when we were talking about the additional prevention benefits, as I read and understood your statement, you are talking about spreading the cost over the entire Medicare population the traditional way and holding the premium share to 25 percent of costs, I take it.

In this day and time, with the constraints of the budget and the problems, do you think they would go for, say, $1.10 per month for these additional benefits if we cannot find the money elsewhere, or do you think we should cut back on these additional benefits?

Ms. MCCAULEY. Well, I think that we need to educate people about the possibility of premium increases, because most of the older people who have Medicare, of course, are fairly satisfied with their health care. Perhaps with continued education and with our efforts to reach out to our members we could show them the importance of that kind of an increase, if necessary.

Half of our membership is between 50 and 65, and they do not have Medicare.

We look forward to having private health insurance market reform, but it should be part of comprehensive health care reform.

The CHAIRMAN. Thank you. I see my time has expired. Senator Durenberger.

Senator DURENBERGER. Yes. Just one question, Mr. Chairman. It begins on the same premise that I started my question to Commissioner Pomeroy, and that is that whenever we sort of standardized insurance as an approach to buying health care, we recognized that expenditures particularly for medical services were expenditures we made on the margin, because we did not have to do it every day.

We had to buy food, and shelter, and clothing, and that sort of thing out of the first dollars we earned, but our medical expenditures were, as you say, on the margin.

And so, we have come to understand that in health insurance, because the purchase is on the margin, as the costs go up and the services become more available, we should put as much of that sort of thing into a health plan as possible.

So, I think I understand where each of you is coming from when you talk about putting in preventive care and mental health, and all that sort of thing, because that simply is what we have gotten used to. It is very difficult now to deal with 900—I think that is the latest number—provider mandates in 50 sets of State laws.

My State I always think is the most egregious, because it includes hair loss for people like me, and facial reconstruction, and a whole bunch of things like that, all of which we have because people have what they characterize as medical needs or health needs, and they cannot pay for them with their food dollars and their shelter dollars, and that sort of thing.

One of the things we have all struggled for for a long time that is included in this bill is what we commonly call catastrophic or stop-loss.

And I wonder if each of you—or whoever cares to—would make a comment about the significance of building into health insurance—into Medicare; into all of these coverage plans—a requirement that we do not put anything on the market unless it has some kind of a stop-loss provision in it so that people can be assured that they have access to medically-necessary services, but, after a certain point in time—I think in this bill it is $3,000; I know that was in my original bill—the expenses are being picked up.

I have not heard anybody express themselves on that yet, and I wonder if you would not comment on it.

Dr. WELCH. Yes. One of the principles that we have discussed in our association, Senator Durenberger, is that when we put in a stop-loss provision like that, there are two principles:

One is that it ought to maintain a principle that the consumer pays some part of what they are consuming, so you always have a financial interest of the consumer involved.

How do you reconcile that then with your goal of making sure they get all their care? It seems to us the solution is to insert that in the context of a graduated copayment based upon people's ability to pay so that you could have a progressive copayment system, if you will, where individuals who are on limited income would pay a lower copayment, but so that the provision you are talking about would kick in earlier; but people who are more able to afford to pay would still go up a little further and have some vested interest in watching their health care consumption.

Senator DURENBERGER. Thank you. Judy?

Ms. WAXMAN. Yes. I would support that, also. I wanted to comment on the State-mandated benefits. As our report of last spring pointed out, there really are not 900. To be fair; there are only about 25 that keep getting repeated in various States.

Senator DURENBERGER. They get to 900 because that is times 50, or something like that.

Ms. WAXMAN. Yes. Exactly.

Senator DURENBERGER. Yes. That is what I meant.

Ms. WAXMAN. And what we found, though, was in States that actually eliminated those benefits, many of the policies that were offered still had the mandated benefits in them, but they raised the cost-sharing dramatically.

That directly gets to the second part of your comment. Many employers found that their employees just did not want those plans; We are actually doing an update on our 1991 report.

But, at least initially in the first 12 States that put those provisions into effect, we found that "barebones plans" just were not being bought because employees realized the plans dramatically point out the inadequacy of under-insurance. We certainly would support some kind of stop-loss, such as the one that you mentioned.

Senator DURENBERGER. Thank you.

Ms. JOHNSON. And I would also like to say that here on the Federal level, we are not opposed to eliminating State mandates, as long as what is put in place is a basic comprehensive package.

I would follow up on that, Senator Durenberger, by saying that we, too, are not opposed to the elimination of State mandates as long as we are looking at an opportunity at the Federal level to assure some minimum benefit package for Americans.

If we are looking at an opportunity to replace State mandates where you do your multiplication and come up with 900 and get into a situation where we have every State deciding on what benefits are essential; and we have perhaps more than 900 lobbyists coming in to influence those decisions on a State-by-State basis, we would have dramatic concerns.

Senator DURENBERGER. All right. Thank you.

The CHAIRMAN. Are there other questions? Senator Riegle.

Senator RIEGLE. Just one very brief question. Am I correct in assuming that all of you would feel that it is time to sort out the options and make the decisions and craft a national health strategy that accomplishes two goals in addition to those that you have mentioned.

One is universal access and coverage so that every last person in the country receives the health insurance protection that they need, and, number two, that we put in place some sensible system of cost control so that we capture and bring under some restraint this spiral in health care costs.

Am I correct in thinking that all of you would support those two goals as ones that we should set out to seek now?

Ms. WAXMAN. Yes, absolutely, Senator. And I would go a little further to say that I am not really even sure that many of the goals of this particular legislation are very laudable and we support them; I am not sure that doing that without cost control, for example, will even work. So, I think we really should do the comprehensive plan right now.

Senator RIEGLE. Ms. McCauley.

Ms. MCCAULEY. AARP certainly would want to have long-term care insurance included with that, too, for all and across-the-board, all generations.

Senator RIEGLE. So, you would agree with the first two, plus long-term care.

Ms. MCCAULEY. Yes.

Senator RIEGLE. Yes. Dr. Welch.

Dr. WELCH. Yes, Senator. I would certainly agree with the first, and I would give a qualified agreement to the second. I think that we clearly need cost controls in the health care system and managed care has a role to play.

I would also like to emphasize, though, that we feel that the management—the managed care entities themselves need to be regulated to protect the consumer, because what we have really done is turn the system from one with incentives to over-treat to one with incentives to under-treat, and there has got to be a protective watch dog mechanism there to protect consumers.

Senator RIEGLE. Ms. Johnson.

Ms. JOHNSON. Certainly we do support the movement, and we think it is very urgent that we work on both universal access and cost containment. I think the other big priority for us, and we are concerned about some of these issues—although they might fall lower on the list—really is thinking about the distribution and availability of providers. For the populations that we are concerned with, those are absolutely critical issues.

Senator RIEGLE. Right.

Ms. JOHNSON. We have no doubt that by making health care more affordable by providing health insurance coverage is a critical first step, but that we know that many people will have a health insurance card with no provider to take it to.

Senator RIEGLE. Right.

Senator GRASSLEY. Mr. Chafee.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Ms. Waxman, in your last words in your statement, you recommend system-wide cost containment. And I have been brooding, as we all have up here, over the ways to guarantee the stabilization, or, hopefully, reduction of cost in health care.

And it seems to me there are only two ways to do this, and if you have got another way, I would be interested. One is to limit what is going to be paid for health services. In other words, put a cap, as they do in Canada, either Federally or regionally. We are going to spend X billion dollars altogether, and that is it.

Ms. WAXMAN. Right.

Senator CHAFEE. Or, to control what is going to be paid for the individual services; you are going to pay the doctors this much, you are going to pay the hospitals this much, and that is it. Am I missing something? Is there another way to meet your goal and our goal, too, but you used the specific words, system-wide cost containment.

Ms. WAXMAN. Right. No. You are correct in stating that those are ways to control costs that we would certainly support.

I do specifically say in the testimony that Congressman Rostenkowski has a comparable bill to S. 1872, and, in that bill, he says, why not do what you would call your second approach and that is, set up Medicare-type rate for providers and let all employers come forth and ask for that rate.

And, in that way, you would stabilize all of the reimbursement system-wide and could accomplish your goal. So, we would support that provision in his bill.

Senator CHAFEE. So, what you have is every doctor in the United States—or regional differences, perhaps—would be paid X amount, the hospitals paid Y amount per day.

Ms. WAXMAN. Yes. It would be based on the principles that have already been enacted in Medicare. I think there would have to be adjustments if you were talking about all providers. You could not use exactly the Medicare rates now, but you could——

Senator CHAFEE. Well, we had testimony the other day, indeed, from a hospital administrator from Texas, and he indicated that the hospitals that are caring for Medicare patients are losing rather substantial amounts per patient, as opposed to what their overall costs are. In other words, others were bearing the costs.

So, I can only assume from that if all his patients were under a Medicare payment type of system, that either the hospital would go broke or the payments would have to be substantially increased.

Ms. WAXMAN. Yes. I am not supporting the Medicare payment levels themselves, I am supporting the principles that they put into place.

Indeed, in Maryland, there is what they call an "all payor system" for hospitals in that State, and they do negotiate with the government on how they are going to set the rates for the hospitals, and all hospitals get the same amount for all the patients that they see.

It has worked very well; it has controlled health care costs overall, and they are thinking about extending that to other providers in the system. And that is the kind of system I am recommending.

Senator CHAFEE. Dr. Welch, just briefly, you talked about deductibles. And I have given some thought to trying to get the individual more involved, that is, the patient. And somehow I do not think deductibles do the trick, because once you have crossed the deductible ceiling you are on your own.

I mean, the sky is the limit; you lose your incentive. Whereas, co-payments, it seems to me, are much more of an incentive. Do you agree with that?

Dr. WELCH. Yes, I do, Senator Chafee. And if I said just deductibles, I should have said deductibles——

Senator CHAFEE. Well, I am not putting words in your mouth.

Dr. WELCH. No. I know. I know.

Senator CHAFEE. But it just seemed to me that deductibles really do not do an awful lot. They deter you from going to the hospital in the first place or using their service, but once you go through that ceiling, as I have said before, your incentives are greatly reduced, are they not?

Dr. WELCH. Yes, absolutely. That was relevant to my comment to Senator Durenberger that the problem is if you can establish a co-payment that is related to the patient's income, then you have optimized your equity cost control mechanism.

Senator CHAFEE. Yes. Now, finally, Ms. Johnson, in the legislation I have submitted, and in the Democratic leadership bill, and, indeed, the administration's health care plan, there is increased

funding for the community health centers. I would just like to say a word.

They are located, as individuals know, in medically under-served areas. Forty-four percent of the patients served by these clinics are children under 18; 30 percent are women of childbearing age; nearly one in ten are pregnant women. And under my legislation we provide for a grant to significantly expand the number of community health centers.

And we have two co-sponsors in this with Senators Daschle and Danforth. I know my time is up, but could you briefly say a word about your views on community health centers?

Ms. JOHNSON. The March of Dimes has for a number of years supported expansion of community health centers, particularly since the Congress, in its wisdom, decided that the Nation should have an infant mortality initiative focused in those centers that ensured greater quality care for prenatal care and for the babies born to women who are served in those centers.

We know that we have seen an impact: better outcomes for those babies; women getting into care earlier in those centers where that Congressional investment has been made. We do support the expansion of health centers for precisely the reasons that you have raised.

Senator CHAFEE. That was an excellent answer. Thank you. [Laughter.]

The CHAIRMAN. Well, with that, we have two more panels, and I see it is noon. Thank you very much for your presentations.

Our next panel today is Mr. John Motley, the vice president for Federal Government relations, National Federation of Independent Business; Mr. Mark Gorman, the senior director of governmental affairs of the National Restaurant Association; Mr. Robert LeMond, who is the chairman of the Texas Society of Architects Trust, on behalf of the American Institute of Architects; Ms. Ree Sailors, the president and chief executive of Florida Health Access Corp.

Mr. Gorman, if you would proceed, please.

## STATEMENT OF MARK S. GORMAN, SENIOR DIRECTOR, GOVERNMENTAL AFFAIRS, NATIONAL RESTAURANT ASSOCIATION, WASHINGTON, DC, ON BEHALF OF THE HEALTHCARE EQUITY ACTION LEAGUE

Mr. GORMAN. Thank you, Mr. Chairman. It is certainly an honor to be here, especially since for 6 years earlier in my career I had a job of sitting behind Senator Chafee up there.

The CHAIRMAN. Maybe that is why he asked to have you testify first. [Laughter.]

Mr. GORMAN. My name is Mark Gorman, and I direct the government affairs activities of the National Restaurant Association.

Today I am testifying on behalf of the Healthcare Equity Action League, which is better known as the HEAL coalition, whose members represent over one million businesses in this country, including 35 million employees.

We are big businesses, small businesses, manufacturers, service industries, insurers, health care providers; it is a very diverse coalition which unites around a central concern—that concern being

that the status quo is no longer acceptable to the business community in the health care area.

Costs must be brought under control, and controlling costs really is the only way of improving access to better quality health care for more people.

The coalition has come together around a set of principles that we believe will help return free market incentives to the health care system and remove anti-competitive pressures that have been imposed in the past by legislation and litigation.

Mr. Chairman, HEAL and its members were enormously encouraged by your introduction of S. 1872, because it incorporates most of the fundamental proposals endorsed by HEAL, and it also draws on a number of provisions that Republicans and Democrats alike have already embraced.

And, in our view, S. 1872 could serve as the basis for enacting legislation during this Congress if Congress, in fact, is committed to passing a bill this year.

Let me outline HEAL's seven principles in relation to your bill, if I may. First, the coalition endorses the full preemption of State health insurance mandates.

Your bill, Mr. Chairman, takes the important first step of preempting State mandates for small employers, as long as they provide a basic health care plan.

HEAL encourages you to take your legislation one step further and provide relief from State mandates to all purchasers of health insurance, large and small.

And it is only by taking measures such as this to reduce costs that we can successfully broaden access to health care.

Secondly, HEAL would like to see the elimination of State laws that restrict managed care. We applaud S. 1872 for recognizing that managed care plans are key to slowing the growth of health care costs.

These programs are providing many cost-cutting innovations in health care delivery, but, unfortunately, there are too many State laws that limit our ability to take advantage of them.

Third, the HEAL coalition is in favor of reforming the insurance market for smaller businesses. Smaller businesses today face an insurance market that is unpredictable, arbitrary, and, in our view, unaccountable to its customers.

In the food service industry that I represent, we hear story after story of insurance companies that cancel or refuse to renew policies after expensive claims are filed; of businesses that experience double-digit or triple-digit annual premium increases, and, of course, of workers with pre-existing conditions that often cannot find coverage at any price.

S. 1872 appears to be fully consistent with HEAL's principles in the area of small market reform, and we encourage you to move ahead as quickly as you can on those.

Fourth: S. 1872 would immediately raise the deduction for owners of unincorporated businesses to 100 percent, that is, the tax deduction for health care costs. HEAL wholeheartedly supports this move.

Fifth: the coalition endorses getting better information to consumers about how to purchase health care and about which treat-

ments are most effective. S. 1872 would authorize money for additional outcomes research, which we believe is an important component of restoring market forces to health care purchasing.

Sixth: HEAL supports cost containment rather than strict controls. Your legislation proposes establishing a commission to study these issues, and HEAL recommends giving this commission tight parameters for its mission to ensure objectivity, as well as a strict deadline for reporting back to Congress.

And, finally, we note that S. 1872 makes no attempt to reform medical malpractice laws, and we would encourage you to add such provisions to legislation that Congress might pass in the future, possibly such as the provisions that Senator Chafee has in his legislation.

The health care crisis is a crisis for employers as well as employees. HEAL believes that enacting legislation like your bill, Mr. Chairman, is the most immediate and most effective way to achieve cost containment and broader access to health insurance in the private sector.

And we thank you for allowing us to work with you and for allowing us to appear here at this hearing. Thank you.

[The prepared statement of Mr. Gorman appears in the appendix.]

The CHAIRMAN. Mr. Motley, if you would proceed.

**STATEMENT OF JOHN J. MOTLEY, III, VICE PRESIDENT FOR FEDERAL GOVERNMENTAL RELATIONS, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, WASHINGTON, D.C.**

Mr. MOTLEY. Thank you, Mr. Chairman. I am delighted to be here today on behalf of NFIB's more than 500,000 members across the country, particularly, it is the second time within a week we have had the pleasure of testifying on a major initiative.

I am also delighted to be here because we strongly support your legislation, S. 1872. We have testified before this committee and others on small business problems with health care many times in the past, and we have shared our studies with you.

What I would really like to do today is focus as much as I possibly can on S. 1872. Let me first of all agree with my good friend and colleague here, Mark Gorman, and say that the status quo is no longer acceptable within the American business community, particularly within the American small business community.

S. 1872, we believe, recognizes that and moves, or attempts to move quickly to begin to address health care problems in small business. Health care concerns, particularly the concerns over the rapidly rising cost of health insurance first showed up in NFIB's surveying in 1986. In a survey called "Problems and Priorities," we give our members 75 choices and we ask them to rank it.

We were very surprised at that time when the cost and availability of health insurance came out as our member's number one concern. And everything else was in there that you could possibly imagine, from Federal taxes to garbage collection.

This year, this quarter, we will publish the 1992 issue of "Problems of Priorities," in conjunction with American Express, and I am sorry to say that the cost and availability of health insurance is still number one. However, today it is double the critical mass of

the number two problem, which you will probably not be surprised to hear, is Federal taxation of business income.

In late 1990, we did another survey which I believe sort of catapulted NFIB into this debate called "Small Business and Health Care," in which we surveyed some 18,000 members on their actual practices; whether they were providing insurance, how they were doing it, how they were sharing costs, et cetera.

One of the disturbing things that we found in that survey was that 91 percent of them in late 1990 said that health insurance was becoming prohibitively expensive and that they were considering dropping health insurance as an alternative if the costs continued to rise. And, of course, we know that in the last 2 years the costs have continued to rise dramatically.

Really, you can describe the small business problem in this area in one word, and that word is cost. Health insurance is being priced beyond the ability of most small employers in the United States to purchase it, and we are very, very worried what that is going to do in the future.

Attempts to control costs on the part of small business owners have not been very successful. Those who have been able to have gone to managed care. Even large employers have not been very successful in that area. They have tried cost sharing of various types.

What I believe has happened during the last 5 or 6 years of trying to adjust to what is happening to the marketplace has led to tremendous middle-class fear over what is going to happen with health insurance in the future.

And I think that is what you saw in Pennsylvania in the last election. I think NFIB members are very, very typical of that type of fear.

Many NFIB members, like the one who came here and testified before—Don Summers, from Austin, Texas—have actually had to give up their health insurance and then have had tragedies strike them afterwards because of it.

Senator RIEGLE. Would you mind if I just posed one question here, Mr. Chairman?

The CHAIRMAN. Yes. All right.

Senator RIEGLE. I have a list in front of me of what the rates and premium growth have been for private health insurance just in the last few years, and I want to read them into the record, because they underscore your point.

In 1988, up 16.9 percent. These are annual increases. 1989, 20 percent increase. 1990, a 17 percent increase. 1991, a 13 percent increase. 1992, a 12 percent increase. There is a certain compounding that is buried in this that makes it even worse than it sounds here.

But, because your members now are coming back and listing the costs and availability of health care in an amount in the survey of the 75 different items or so that they have responded to, that one is more than twice as large as the number two item, which is Federal taxation——

Mr. MOTLEY. Yes.

Senator RIEGLE.—would it be fair to conclude that the health care issue is threatening the economic viability of more and more of our companies?

In other words, it is an economic issue, as well as just a question of wanting to protect one's employees and help one's employees, and so forth, and most small business people have that very strong desire, because most attempt to offer health insurance.

But the sense I am getting is it has actually become a clear and present danger to the survival of more and more companies because the cost is just something they cannot handle. Is that right?

The CHAIRMAN. Could I interrupt? And I appreciate the statement, but I have to make a comment to the caucus in just a few minutes. And I would like to hear the other witnesses, and then respond to this, if we may.

Senator RIEGLE. Very good.

The CHAIRMAN. Later, please. Thank you. Now, let me see. Where were we? Had you finished, Mr. Motley?

Mr. MOTLEY. No, I had not, Senator. I can sum it up pretty quickly in simply saying we support S. 1872 so strongly because we believe that the one thing that it will do will be to stabilize the small business health insurance marketplace.

In addition, it will offer affordable insurance choices to those marginal small firms who cannot afford to purchase it today, and it will provide real incentives to purchase health insurance to the largest single class of small employers in the country, and that is the self-employed. We believe that it recognizes the fact that the status quo is no longer acceptable and that we must begin this process now.

And I emphasize the word, now. I do not believe that the small business community of this country can afford to wait until after the political debate surrounding health care is finished. We would very much like to see you move forward; we would very much like to see you sit down with the administration and other employers in this game, because many of the elements in your bill, many of the elements in the President's package are very similar.

And we are sure that an agreement can be reached and that a piece of legislation can move through the process and hopefully be signed into law before the November election. Thank you, Mr. Chairman.

[The prepared statement of Mr. Motley appears in the appendix.]

The CHAIRMAN. Mr. LeMond.

## STATEMENT OF ROBERT LeMOND, FAIA, CHAIRMAN, TEXAS SOCIETY OF ARCHITECTS TRUST, FORT WORTH, TX, ON BEHALF OF THE AMERICAN INSTITUTE OF ARCHITECTS

Mr. LEMOND. Thank you, Mr. Chairman. My name is Bob LeMond. I am a self-employed architect from Fort Worth, TX. Let me express to you, sir, what an honor it is for me to be here today, not only personally, but to represent the American Institute of Architects.

On behalf of our 56,000 members in the AIA, let me also commend you on your leadership in bringing accessible, affordable health care to the American people.

Your legislation embraces the incremental approach to health care reform advocated by our organization and avoids immediate restructuring of the entire system, to the detriment of quality, technology, and research.

Known by all, Mr. Chairman, is the enormity of the comprehensive task ahead of you all. With the health, and ultimately the lives of the people at stake, and trillions of dollars of the Nation's wealth, there are created colossal questions.

I prefer problems like we have back home, little problems that we deal with across a fence, or across a table, or across the hood of a pick-up truck. That seems to be the only way my mind will work, and I deal with these enormous questions by reducing them, translating them into a managed, modest term.

The problem here, I think, would reduce itself to a three-legged stool, and I will call the stool 'ability: affordability, accessibility, and portability. Each leg must be dealt with and kept under scrutiny or we will all take a tumble.

The AIA endorses the concepts of your legislation and I wish to examine just a few of those here today, keeping that stool very level.

First, affordability. The permanent increase in the tax deductible insurance cost of a self-employed individual—the norm in architectural practice—is a must. Architectural firms are in a strange situation in regard to deducting the cost of health insurance.

In most States, architects may not incorporate by State law. Three-quarters of the 17,000 firms of AIA members are not incorporated, and, under existing law, may only deduct the 25 percent allowable.

This is particularly onerous, since a third of the 17,000 are sole proprietorships, and most of the rest are partnerships.

Two-thirds of the AIA members' 17,000 firms consist of four employees or less. We are truly small business people. And only a third of our individual practitioner firms provide insurance; a dramatic decrease with the economy in the last few years, compared to 99 percent of firms with 20 or more employees, or larger firm normally in a corporate mode.

That is the reason we seek this easily obtainable 100 percent deductible for the self-employed: to gain parity with the corporations. It is patently inequitable that small businesses are treated differently than corporations. If time permits, I could deal with some of the other aspects of cost containment in a moment.

The second leg of the stool is accessibility. I just attended a very timely meeting in California with our new insurance carrier. The new insurance carrier just for our Texas Trust offers 5,600 rating categories. 5,600 rating categories is several times more than the people we have insured in Texas.

I guess the computer has brought us to this age, Mr. Chairman, but I long for those thrilling days of yesteryear when a group was a group was a group. And that you could take a group and spread the risk over the entirety of that group, rather than having individual pay-as-you-go profit centers for insurance carriers.

The third leg of the stool, obviously, for small business people, is portability. Your legislation deals with this problem very well. Architect employees change jobs frequently by changing firms, by

seeking areas of the country where there is a possibility of construction, and portability is a must.

Thank you again, Mr. Chairman. I want to thank each member of the committee for their hard work. I will offer you the resources of the American Institute of Architects and its membership in seeing that this type of health care legislation is enacted, implemented, and the hard road begun.

We are gratified, again, by this opportunity. We wish you Godspeed, abundant wisdom, and Herculean courage for the job ahead.

[The prepared statement of Mr. LeMond appears in the appendix.]

The CHAIRMAN. Well, I have a hunch, Mr. LeMond, you could bargain rather well over the hood of a pick-up truck. [Laughter.]

Ms. Sailors, we are pleased to have you.

**STATEMENT OF REE SAILORS, PRESIDENT AND CHIEF EXECUTIVE OFFICER, FLORIDA HEALTH ACCESS CORPORATION, TALLAHASSEE, FL**

Ms. SAILORS. Good morning, Mr. Chairman, and Senator Riegle. Thank you for the opportunity to talk to you. I am Ree Sailors. I am the president and CEO of the Florida Health Access Corporation, which is a strange critter created by legislation in Florida that calls for a private, non-profit corporation whose sole mission is to try and find ways to bring affordable health coverage to uninsured small businesses.

I have come to talk specifically about what we do and also about the provisions in your bill for grants made to the States in order to help this type of organization proliferate, I hope, in the future, not only throughout Florida, but throughout other parts of the country as well.

One of the things that we do is that we come together and pull small employers together for the sole purpose of insurance. We do not pretend to exist for anything else. We bring them together, all different kinds; from Kramer's Worm Ranch to a couple of small farms owned by families, to appliance repair shops, to Insty-Prints, to yogurt shops, to glass plate cutting businesses, to packaging businesses. You name it, we have got it.

We have over 2,400 small businesses, all of whom were previously uninsured and unable to provide benefits to their employees. We have over 10,000 employees and dependents enrolled in the program now.

It started as a joint venture between the State of Florida, the Robert Wood Johnson Foundation, and one of our counties, Hillborough County, in the Tampa area of the State.

We decided to tackle the problem by, one: bringing small businesses together for the purpose of the aggregate pool risk, which the insurance people look at as desirable.

Two: to try and perform what appeared to be the expensive front-end administration which tends to drive up the costs in a small group market rather than what I would affectionately call the rear-end administration, which is the claims processing side.

It is the marketing, and billing, premium collection, and so forth that is difficult when you have many, many tiny, tiny businesses.

So, we decided that we would take on that and that the State of Florida, through appropriation, would actually support the expense of that administration and allow it not to be passed into the premium of these small businesses.

Likewise, the strategy was to, amass the clout of a group of buyers, with the State of Florida supporting an administrative infrastructure on a regional and local basis—which is what the health care market is about—so that it could leverage; so that it could negotiate; so that it could bargain; and so that it could marshall the resources of the small business community together with State government.

What we have done is sort of put a hoop around money that the small employer had but was not enough to break into the market; money that the employees in small business had but was not enough to break into the market; and money that the State had but was not enough to cover the population at risk, too.

We brought them all together, turned them into a coordinated buying power and began negotiating in the markets for health coverage. We think our program is very successful and we are very proud of it.

Two-thirds of the people enrolled in it are dependents and children, which we know are a population that often does not get covered because of the prohibitive cost of dependent coverage for workers.

The small businesses that we deal with are the size that I call the real micro business. I think we actually coined the term "micro business," in this discussion. Our average enrolled business has three employees.

I bring this to your attention because I think oftentimes we get lost in the conversation of small business. We think 100 is gigantic by our standards; 50 looks incredible.

In Florida we have over 310,000 small business in the State, however, 70 percent of those businesses have four or fewer employees.

And often, as we try and create solutions for the small business/small group market, I think we tend to glop it into the 10-and-above, which is a whole different set of problems from what we deal with when we see the three-and-under size and the four-and-under size business that we specialize in.

I think also what we have tried to do is we listen to the employees and the employers in these small businesses and asked them what they wanted, and they did not ask us for stripped down, dune-buggy packages.

What they said was, we do not understand why the size of the business is going to make a difference between whether or not my kid has coverage, and they want to be like regular people and have regular coverage. And so, we went after that. However, what we tried to do was to provide our technical assistance and buy smart.

We began buying managed care, full comprehensive packages where basically the principle that we are trying to take to our membership is, if we keep buying it the way we have been buying it, if we all stay healthy, they all go broke.

If we start buying it this way, it might be better if they got wealthy if we stayed healthy, so we are going to hunt for those kind of providers to do business with.

What we are basically trying to do is change the rules of the game—change the rules upon which we, as collective small business, and we, as one of the three-legged stool, if you wish, of three major buyers—government, large business, and small business—want to change the rules and say these are the conditions upon which we will release dollars to you for health care.

And we want to change even the fundamental basic unit of exchange, if you wish. We are no longer willing to buy it one nut and bolt, and tire and hub cap at a time. We want to buy it by the package, and we want to buy it from people who have organized themselves to offer that.

And if insurers want to make money off the cash flow of our premium payments, then they are going to have to interject themselves into the health care delivery system and start managing it.

The CHAIRMAN. Good statement.

[The prepared statement of Ms. Sailors appears in the appendix.]

Senator RIEGLE. Let me thank you all, and indicate that what is transpiring in another location right now is a major meeting today on the whole question of constructing an economic recovery strategy, both near-term and long-term, for the country, which the Chairman, who just left, has to participate in and make a presentation on.

And others of us will have to do that, too, so we are going to finish up here shortly. We have another panel left to go.

Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you very much. Needless to say, I am not included in this meeting.

Senator RIEGLE. I will take any ideas you have. [Laughter.]

Senator DURENBERGER. I will leave you to conjure up who is going to solve the economic woes of America.

But I want to apologize to those of you whose full statements I did not hear, and to tell you, Mr. LeMond, that I appreciated your statement very much, because it illustrates not a very unique professional concern that a lot of people have.

And, John, thank you, in particular, for your leadership in small business on a lot of issues, but particularly on this issue.

I thought that the statement that I did hear at the end—and I guess I got the front part of Tom's and Ms. Sailor's—is most impressive because you got kind of to the heart of the point, which is let us stop buying the tires and the hub caps and all that sort of stuff separately and start buying cars in this country.

And, as I was listening to one of my colleagues earlier ask a question about what is the best way to contain costs, they said, it is either to regulate prices or go to a budget. There is a third answer, and you just gave us the third answer.

Ms. SAILORS. That is right.

Senator DURENBERGER. And that is, buy health, buy a package, buy the whole package, buy the whole car. If you do not want to buy a $50,000 car, stop paying $50,000 for a $20,000 car. It is not that complicated. What is complicated is figuring out what is the

$20,000 car. But unless somebody gets started, as you have, it is not going to happen.

And one of the important reasons, obviously, that we are doing this kind of reform is that we all need help in making those decisions: who are the most efficient providers of health care; how much do we really need and who should we buy it from. That is what we need. We do not need bill paying services anymore, such as represented by so much of history in this field. We do not need that anymore.

We need what, as individual buyers, we cannot get when we are just one at a time, four at a time, three at a time, we cannot do it. That is the kind of help we need from what is called the insurance industry, or the health plan industry in this country.

One of the questions that keeps coming up is about the individual person. One of the great things about this bill, of course, as we all know, is we finally got 100 percent deductibility for the self-employed after struggling on this committee for a long time to do it. Now we have got 25 percent. This bill would give us 100 percent deductibility. But the other key question is on the insurance side.

My original bill went from one to 50. This bill is two to 50, and we are advised by the industry that you cannot get into this individual market. Can somebody tell me why it is impossible to get into that market? John?

Mr. MOTLEY. Well, maybe I can take a shot at it, if you will let me say in the beginning that I am not really a technical expert in the area.

But what they tell us is the problems of adverse selection would be very significant and that you would basically have businesses or individuals who did not want to purchase insurance hanging back to the point where they would need it, and then, in effect, asking for insurance with a pre-existing condition, which would be very expensive.

And that would cause very serious problems of adverse selection. They do not want to slow down or muddle up the move toward what they consider to be small market reform by adding that at this time.

I think you will notice in our statement that we say it really has to be dealt with somewhere, and, for the sake of moving something quickly because the insurance market in this country has to be stabilized, it really has to, or else we are going to have a constituent revolt across the United States.

For the sake of quickly moving on, I think we are all willing to say that that may be a problem we can deal with a little bit later on. I do not have the answer. It does have to be dealt with, and 100 percent deductibility is a partial answer, but it is not the complete answer.

Senator DURENBERGER. Ms. Sailors.

Ms. SAILORS. Senator, I am a lay person in all of this, but, to me, I have heard those justifications before too, and it does not make a whole lot of sense to me if you think about what else is in the bill, which is basically an abandoning or an outlawing of underwriting so that risk selection is no longer in their control.

They have to provide insurance to anyone, all comers, irrespective of their health status, and they do still have the pre-condition situation available to them.

It seems to me that the sole, single person, the individual—the main barrier remaining for that individual is affordability. And one of the things that we do is we, likewise, administer a subsidy to these groups, and I think that still remains an issue.

But I think on the side of the legislation, that you have begun to remove the barriers for the one and remove the argument of adverse selection because you have opened adverse selection up entirely. And you do still allow at least one pre-existing.

Senator DURENBERGER. The other thing I would hope you could help us think about in the next week at the most, probably, is how to persuade the bigger companies who have been using Federal preemption to think a little bit differently about some modifications on Federal preemption.

Because we really are not going to be able to do fully what we would like to do for individuals or small businesses unless we can find some way to take care of the medically uninsurable and some of the more serious cases on a State-by-State basis, out of some kind of pooling or reinsurance arrangements, and we need everybody who is providing health care for employees to be part of that.

And I know we need to protect them against the artificial mandates of the so-called 900 benefits, or the 25 benefits, or whatever.

But if there is some way to persuade those big companies and those self-insureds that some modification of preemption would help, I think now is the time for those who represent the majority of employed people in America to help us come up with an answer to that.

Senator RIEGLE. Mr. Motley, let me ask you to answer a question I posed earlier, and that is, I take it that the reason that the health care costs and access is at the top of the list of your members is, in addition to the concern that small business owners have in human terms, I take it this is a very compelling economic issue and this is really threatening just the economic survival of a lot of companies. Am I fair in assuming that, or not?

Mr. MOTLEY. I think you are more than fair in assuming that. You cited some statistics on increases in rates before and you can probably take those and double them and triple them for most small businesses.

I do not think you will find anybody who knows anything about the field that will tell you that a small business' rate increase was anywhere near those that you cited.

Senator RIEGLE. Right.

Mr. MOTLEY. Those were averages across the country.

Senator RIEGLE. Yes. A very good point. So, I think this element of the discussion has been under-developed, if you will, and that is that there is an enormous economic imperative here that has to be dealt with from the point of view of the health, and well-being, and strength, and growth of small business.

I mean, one of the things I am so struck by as I look across the country, so much of our job base comes from small business, and it can be very small firms of one, two, three, four people, but ranging up from there.

As we watch the big companies in America announcing all of these permanent jobs reductions—General Motors, 74,000; United Technologies, 14,000, and go right down the list: IBM, AT&T, it is the who's who of business firms in America—if we have got an economic factor that is, in part, crushing small business, and small business viability and small business growth in the jobs and economic strength created there, I view that as a real threat to the economic well-being of the country.

I think it is an economic issue that poses a real danger to us, and it has to be dealt with because we cannot afford to have any more damage done to small business in this country.

Mr. MOTLEY. Unfortunately, Senator, there is a safety valve for the business community here, and that is that health insurance is a fringe benefit.

And I think it is remarkable that you do not see more firms jettisoning their health insurance. They are trying everything short of that to keep it such as trying various types of cost-sharing mechanisms. But, the ultimate answer is, like Don Summers, who appeared before this committee before——

Senator RIEGLE. Right.

Mr. MOTLEY.Is basically to gather his employees together and say, I cannot afford this. I will give you each a check, or I will increase your salary for what it costs me now. But future increases, you are going to have to take care of yourself.

And I do not think mandating it on all employers is good for the economy. The job destruction that will take place because of that is going to be phenomenal. And I do not think you want to lock those kind of rigidities into the American economy.

Some of the European models that are out there have tremendous, heavy, government subsidies and high taxes to pay because those rigidities are built into the economies and into the employer/employee relationship.

Senator RIEGLE. Let me read to you a letter, and just take a minute and do this, and then we have got to go to our last panel. I headed a health care hearing recently out in Michigan, and a very large number of people came; many of them small business people. And, in fact, some testified, and others left statements.

One of the women who came to testify is self-employed, as you will hear from this letter. Her name is Janet Regan. She lives in Warren, Michigan. She has her business card and her husband's business card here.

She attached a copy of her Blue Cross/Blue Shield billing payment that she had received, and she left it, as you will see here, because she was at a point where they were having to discontinue it.

Had they been able to pay their premium for that premium period, it would have expired today. So, it is significant that the date through which they would have had coverage was actually today's date.

But listen to what she said, because she, in effect, and others like her, I think, fall into the category that you all are speaking for.

She said this: "Attached please find a copy of my Blue Cross/Blue Shield bill for a three-month period for my family of three. You can

have it, because I cannot pay it. I am self-employed as a realtor and have been in the business for 7 years. My husband is a self-employed contractor as well.

We get no help with insurance because we have no regular income to deduct it from. My mother is dying of breast cancer that has spread to the bone. My sister-in-law died August 15, 1991 of breast cancer at 49 years old, leaving two sons, one still in high school.

Fortunately, my mother is a widow of a Chrysler executive and has Blue Cross/Blue Shield and Medicare. My father died of cancer at 54 years old, after 30 years on the job.

Please consider at this point my chances of getting the disease myself and my need for mammographies and careful preventive care.

My husband's mother died of cancer in October 1988. His sister died of cancer last August, as noted on the front of this statement. She worked, she got sick, she had a breast removed and recovered.

She thought she would try to return to work. Her job was gone; she had been replaced. Now her health insurance was gone as well.

By the time she was able to get through the red tape to be eligible for Medicaid, her cancer had spread—spread so far that she could not recover. She was arrested for driving to her chemo treatment in a car with no car insurance.

In the end, she was taken to Harper Hospital, where she received excellent care, but it was too late. She had rotted inside, her organs so full of cancer, she developed gangrene in her bowels and intestines.

Many thousands of dollars were spent helping her in intensive care for three weeks, to no avail. Obviously, no help when she needed it." You wonder how many people are out there right now with these ticking time bombs in them, men and women.

She concludes, "We are angry and scared. What about us?" She says, "You have health insurance, don't you," which I take to be addressed to all of us in government, and the answer to that is yes.

If we did not, by the way—if the health insurance for all of us in the government disappeared today, I think we would probably have a workable plan within hours to put it back in place.

All of these excuses and arguments about how it cannot be done, and this, that, and the other; and it's too difficult, and all of the bobbing and weaving would all end if the government insurance disappeared and it took a national program to put it back in place. And we would have one within hours.

The thing that bothers me when I hear stories such as you have related or the one right here, I think of an architect who may be a single proprietor, or have two or three people with him, if he is finding some business to do, or the kinds of small firms, Ms. Sailors, that you have been working with in Florida, you know, the struggle and the wealth that is created in this country by entrepreneurs who are willing to go out and make an effort to try to make something happen in this country; employ themselves and provide employment to somebody else, the fact that they have got to live with this kind of anxiety and lack of health care coverage on things as fundamental as being able just to stay alive is really outrageous.

I mean, that we should find ourselves in 1992 in here, not just today, but in the other hearings, and we chew these issues over, and we chew them over, and so forth, and so on.

I think we have got to have some answers here. I think we have got to get some coverage out there that is affordable and in place for people before it is too late.

And we do not just end up, after somebody is full of cancer, providing intensive care for three weeks when it is really too late to really do anything about it, and probably at costs that it would shock us to hear.

I mean, we probably could have spent, in some of these cases, at least, a fraction of the costs with preventive care and so forth, earlier on, and prevented these kinds of terribly sad outcomes.

But I think it is not only a human decency issue and an issue of humaneness and how we ought to think about our basic human needs, I think it is threatening the economic system.

I had one of the top business people that I know in Michigan, who has been one of the great innovators in his field, tell me about 6 months ago that he had to discontinue health insurance for all of his employees, and he felt wretched about it—including himself because he is trying to save his business in this lousy economic climate.

And he does not have the money to pay the health insurance premiums and he is laying awake nights tossing and turning because he wants to be able to provide that benefit for his workers which he has done before, and for himself, and he cannot afford it. And he cannot afford it because the system is not working properly, and there is just no excuse for it.

The fact that we say we cannot get it fixed is nonsense. We fixed it for ourselves. Insurance is in place today for everybody in the Federal Government, from the President right on down.

So, if we can get it fixed there, we ought to be able to get it fixed for everybody else, especially for the business people out in this country that are trying to make this system go.

Thank you very much for your testimony.

Mr. MOTLEY. Thank you, Senator.

Mr. LEMOND. Thank you, Senator.

Senator RIEGLE. Let me now call our last panel. Bruce Butler, who is the president of the Managed Care and Employee Benefits for Small Business, The Travelers, from Hartford, CT, and Mr. Richard Niemiec, who is the senior vice president of underwriting, actuarial, and legal; Blue Cross/Blue Shield Association of Minnesota, from St. Paul, MN, on behalf of the Blue Cross/Blue Shield Association.

We are delighted to have you. And Senator Durenberger, I know, particularly, will be interested in what you have to say and will be back in the room, momentarily.

Mr. Butler, we would be pleased to hear from you now.

**STATEMENT OF BRUCE BUTLER, FSA, PRESIDENT, MANAGED CARE AND EMPLOYEE BENEFITS FOR SMALL BUSINESS, THE TRAVELERS, HARTFORD, CT**

Mr. BUTLER. Thank you very much, and good afternoon. My name is Bruce Butler. I am president of The Travelers' Managed

Care and Employee Benefits operation for small business. With me are Helen Barakauskas from our Hartford office, and Carole Roberts, of our Washington office.

Travelers is one of the largest commercial insurance carriers in the small group market. Small group cases include businesses with two to 50 employees, and we insure nearly 800,000 employees and dependents in 40,000 businesses.

One-third of the lives covered are covered through associations such as Chambers of Commerce and State manufacturing associations.

Travelers has been, and is very committed to the small group market. It is our objective over the next 5 years to double the number of lives that we have covered in the small group market.

The small group market needs to be reformed. The problems in this market have developed over the last 5 to 10 years. They are well-known to the committee, and I would be happy to address them in the question and answer period.

Travelers is pledged to reform of the small group market. We are very aware of the practices of the industry that are not conducive to the widest coverage of employees in this market.

Over the last 3 years, we have supported legislative reform. We have been successful in passing small group reform legislation in Connecticut, and have and are supporting the efforts of the Health Insurance Association of America to bring about small case reform in 15 targeted States.

We are pleased that small case reform has, in fact, been adopted in several States: Connecticut, Massachusetts, and North Carolina.

The key points to small group reform which Travelers supports, and which are supported generally by the Health Insurance Association of America, include the following: guaranteed issue without regard to health status; guaranteed renewal of insurance without regard to health status or claims paid; continuity of coverage—that is, limitations on pre-existing conditions exclusions; rating restrictions and rating bands which limit the rate increases that may be requested; and a reinsurance mechanism to take care of the high-risk individuals or groups.

More broadly, The Travelers also supports (1) Medicaid expansion, or expansion of public resources to cover the poor and near poor. We think this is an example of our belief in the public/private partnership; (2) managed care, which involves overriding State laws which are frustrating the expansion of managed care programs; (3) low-cost policies, including overriding State laws which impose mandates on employers or insurance companies; and (4) finally, medical malpractice reform.

I will talk for a moment about community rating. First of all, let me define it. Under community rating, each carrier would charge the same rate for each business. There would be no distinctions based on health status, age, sex, or industry. In effect, one person; one rate.

We note that community rating is not in the Bentsen bill, and we commend the Chair of the committee for not including community rating. We believe that the rating band approach is the approach to follow.

Community rating has a ring of fairness and reasonableness. It sounds attractive. But, in fact, we believe that community rating drives up the average cost over time.

The reason for this is that rates go up immediately for the lower cost groups—perhaps as much as 60 percent of the employers—based on our own book of business, and these employers will not understand this.

In turn, these lower cost groups, usually those with younger employees, will opt out, since they have low utilization of claims and would object to the increases in their premiums.

Further, with community rating there are no incentives for healthy practices on the part of employees; no incentives for employers to contain costs or to be conscious of costs; and, finally, community rating is contrary to managed care which provides cost differentials based on the efforts that the employer and the carrier make to contain these costs.

Let me turn now to the Bentsen bill. We prefer State-level reforms, however, the Chairman's bill, by featuring market-based reform, is far more desirable than employer mandates or play-or-pay.

We support many aspects in principle, and some in detail. We have three concerns: the rating bands are too tight; the size of the group is too large—it should be 25 employees and under—and the managed care standards are too detailed and would limit innovation.

Let me summarize then as follows: we need industry reforms to eliminate the extreme industry practices and to hold down the costs to the higher cost groups.

This, then, allows the industry to focus its attention on driving down the average costs through the use of managed care, the economies of scale, and the use of automation to drive down administrative costs.

We appreciate very much the opportunity to be here today and to have our views be heard. Thank you very much.

[The prepared statement of Mr. Butler appears in the appendix.]

Senator DURENBERGER. Thank you very much. Mr. Niemiec.

**STATEMENT OF RICHARD M. NIEMIEC, SENIOR VICE PRESIDENT OF UNDERWRITING, ACTUARIAL, AND LEGAL, BLUE CROSS AND BLUE SHIELD ASSOCIATION OF MINNESOTA, ST. PAUL, MN, ON BEHALF OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION**

Mr. NIEMIEC. Senator Durenberger, as you know, I am Dick Niemiec, senior vice president of Blue Cross and Blue Shield of Minnesota. I welcome the opportunity on behalf of Blue Cross and Blue Shield to present our views on S. 1872.

The Blue Cross and Blue Shield system believes that reform is needed in the small group insurance markets to ensure that all small employers can purchase coverage, regardless of their health status or past claims experience, and to stabilize premiums charged to small employers.

In January of last year, the board of directors of the Blue Cross and Blue Shield Association adopted a small group insurance reform proposal based on many of the same principles found in S. 1872.

We congratulate Senator Bentsen for recognizing the problems of this market that are addressed in his bill. Blue Cross and Blue Shield of Minnesota has been pleased to work with you, Senator Durenberger, on the elements of small group reform as we see them working in Minnesota.

We support many of your bill's provisions, including the need for State flexibility in ensuring availability of private insurance coverage for small employers.

In addition, we support your recognition of the importance of managed care programs. In Minnesota, managed care programs have long been a central part of our cost management strategy.

The effectiveness of managed care is confirmed by a survey conducted by A. Foster Higgins, which reported that Minnesota businesses paid premiums 18 percent less than the national average. This difference was not there in the past.

Much of the reason for these lower costs can be explained by the prevalence of managed care coverage in Minnesota. Approximately 60 percent of residents are covered in managed care arrangements.

Our key concern with S. 1872 is that the rating limits in the bill are too restrictive and result in substantial rate increases for many small employers. For this reason, we are opposing rating restrictions that are tighter than recommended by NAIC.

In a voluntary environment where there is no employer mandate, restrictive rating requirements such as community rating provisions would result in significant rate increases for many small employers.

As a result, many of these employers would drop coverage rather than pay the higher cost. Actual data from six Blue Cross and Blue Shield plans shows that over half of the small employers would receive rate increases under community rating proposals. Some small employers would see their rates increase by over 100 percent.

Other factors would also increase rates for small employers, including health care cost inflation, as well as the added costs of guaranteed availability requirements.

As a result of these additional factors, small employers would receive a 50 percent rate increase as a result of community rating, and could, in fact, receive a total rate increase of nearly 100 percent.

The rating provisions in S. 1872, with the modifications we suggested, would benefit small employers significantly. Premium rates would be much more stable and predictable, and the use of a small employer's own claim experience or health status in setting its rate would be limited.

We believe that the small employer market could tolerate the rate increases resulting from these changes without encouraging more small employers to drop their current coverage.

We also believe that States need additional flexibility to modify the NAIC standards established under the bill. None of the NAIC model approaches have been proven, and they are not mature enough to be frozen into Federal law.

States that have already enacted the NAIC model laws have found it necessary to make substantial changes in the models prior to enactment.

In addition, we believe the provisions in the bill should be restricted to the three to 25 market, where most of the problems with availability of insurance arise.

We would not object to application of the guaranteed availability, guaranteed renewal, and continuation of coverage requirements to employers over size 25, so long as carriers were required to manage the full risk of these groups.

We do, however, oppose applying the rating requirements to these larger groups. While pooling the costs of larger and smaller groups would lower the rates somewhat for smaller groups, it would increase the rates for larger groups.

On the lower end, we recommend against including group sizes one and two in small group reform proposals because groups of this size are especially likely to purchase coverage only when it is needed.

Inclusion of these high-risk, higher cost individuals would increase overall costs in the small group market. This is especially true in the voluntary market where healthy small groups and individuals can choose to remain without coverage.

With respect to the scope of the bill, we are concerned that the bill may exclude certain self-funded insurance plans from its requirements, including MEWAs.

Any insurance market reform must include all entities providing or financing coverage to small employers, whether insured or self-funded. If not, imbalances in the market would result and incentives would arise to move towards unregulated entities, therefore undermining the very purpose of the reforms.

Relative to the small employer purchasing groups, we do not oppose the start-up grants provided in S. 1872, however, we do object to the preferred tax treatment and the exemption from State insurance laws provided to these groups under some proposals.

Finally, another concern we have is the idea of extending Medicare payment arrangements to all payors. We are concerned that this would stifle innovative managed care arrangements.

For example, Blue Cross and Blue Shield of Minnesota pays C-sections at the same rate as normal deliveries. This is an example of incentives where we have to strike a deal with the providers.

In conclusion, we understand that reforming the small employer marketplace will not solve the health care access on its own. However, these reforms will provide necessary protections for small employers, and we believe they are a good first step. Thank you.

[The prepared statement of Mr. Niemiec appears in the appendix.]

Senator DURENBERGER. Thank you, both. Let me ask some questions of both of you, and if you both want to respond, fine. Otherwise, I will leave it up to you.

The first question is a general one, and that relates to defining what an insurance plan is and where do the—in other words, the product we are talking about is called insurance, and it has a price on it called a premium.

And that price seems to vary all over the lot for the same product. And my question is a crudely crafted question to try to find out in the market today what is in that product and what we are paying for it.

I assume that part of the product pays doctor bills, hospital bills, and other provider services. I assume part of the price of the product pays marketing, sales, commissions.

I assume part of the product pays the expenses of claims administration on the part of the provider, on the part of the consumer, et cetera. I assume part of the product is reserves; part of it is profit, and so forth.

Can one of you give me a general idea in America today for however many folks that are out there selling this thing called health insurance how that usually breaks down, or if it does not have a usual breakdown, give me some idea of where the variances are?

Mr. NIEMIEC. Well, Senator Durenberger, if I could respond.

Senator DURENBERGER. Please.

Mr. NIEMIEC. One element I do not believe you included in your list is the cost of managed care programs, and that is becoming more and more a cost of what is called administrative expense.

But the value that it returns as far as eliminating unnecessary care and developing effective networks, brings value to the member.

As far as how those elements break down, Blue Cross and Blue Shield plans typically charge less than 10 percent for all those administrative claims processing/managed care types of arrangements. We are non-profit.

The one variable that you will find is that because the cost of sending bills to small employers versus large employers—one bill per employer, involving 1,000 or two employees—is going to vary.

So, there is some inherent costs with small employers that would mean that they would have higher retention costs than would larger employers.

But the goal with all is to keep those expenses down and to work on electronic claims submission.

In adding we have to set up a reserve under State law. That is something that, if it gets too high, it is returned to the subscriber.

In other words, it is simply putting something in 1 year that you are going to have to take out another year.

Senator DURENBERGER. Mr. Butler.

Mr. BUTLER. I would agree very much with what Mr. Niemiec said, and, again, would note that the reserve that you set up classically runs out over a very short period of time. And when I say a short period of time, I am talking in terms of 3 months. So, you are really talking about a very short displacement of time.

We talked, too, about commissions that are paid to the agents. I think it is very important to understand that in the small case marketplace, the agent is, in fact, in many ways, the employee benefits expert for that small employer.

Employee benefits or the insurance program classically at the small end of the marketplace is handled by, perhaps, a part-time bookkeeper. Day-in, day-out, that person is not even on the premises.

And an agent, oftentimes, in fact, is, therefore, filling in that spot. If you have a large employer, that large employer will, in fact, have an employee benefits administrative area on site, day-in, day-out to help out the employees and their dependents with their

questions. That is the role that the agent, in fact, is really filling in many ways.

So, I think it is very important to understand that commissions is not purely, in my opinion, a selling expense; it is, in fact, a selling and servicing expense.

We have agents who, in fact, help people fill out the claim forms so that they get through the hassle factor we heard about earlier this morning and get the claim processed right the first time.

Senator DURENBERGER. Well, maybe it was not fair to ask you that question and expect an oral response, but it certainly would be helpful to—since this is the industry that is under attack by everybody else who wants to do comprehensive reform, everybody throws around these, Medicare costs only 3 percent to administer figures, and if Blue Cross is ten percent, then a lot of people are probably more than ten percent.

And we do not even know what is behind all of that. It certainly would be helpful to get some idea of what it costs to buy a product that delivers something other than doctor payments or hospital payments.

If it costs extra to do managed care, or is that a cost-saver? How does that system work? How much are we paying to an agent just to go around and sell little groups of three, or four, or five people?

I take it there is a savings there if you move in the direction of a health insurance network, or something like that, if you go to a Florida, you go to a COSE, or you go to something else. I assume there are some fairly substantial savings in that part of the system as well.

Mr. BUTLER. I am not sure we would conclude that yet.

Senator DURENBERGER. Pardon me?

Mr. BUTLER. I am not sure we would conclude that yet. And that basic service that I just mentioned, somebody is going to provide that service. And the employer, as I said, classically does not provide it.

So, somebody is going to have to provide that service. Whether you change from an agent, or a health insurance network, or a health purchasing group, that basic service to the employees and dependents is going to have to be done. And I am not sure that you are really talking major savings when you do that.

Mr. NIEMIEC. Senator Durenberger, if I could respond just briefly as a follow-up. We would be glad to submit to you some breakdowns of our administrative costs and other things, and vary it by group size, and reflect managed care.

Mr. BUTLER. Yes. We would be happy to provide that.

Mr. NIEMIEC. We simply cannot cover it now.

[The information requested follows:]

THE TRAVELERS MANAGED CARE & EMPLOYEE BENEFITS OPERATIONS EXPENSES AS A PERCENTAGE OF PREMIUM

| Type of Expense | Employer Size (No. of Employees) | | |
|---|---|---|---|
| | 2–9 | 10–24 | 25–49 |
| Indemnity Business Costs: | | | |
| Claims Processing | 3.2% | 3.1% | 3.0% |
| Sales & Administration | 17.6 | 8.9 | 6.2 |

THE TRAVELERS MANAGED CARE & EMPLOYEE BENEFITS OPERATIONS EXPENSES AS A PERCENTAGE OF PREMIUM—Continued

| Type of Expense | Employer Size (No. of Employees) | | |
|---|---|---|---|
| | 2–9 | 10–24 | 25–49 |
| Commissions | 9.0 | 6.5 | 4.4 |
| Premium Tax | 2.2 | 2.2 | 2.2 |
| Additional Cost for Managed Care Features: | | | |
| Utilization Review Only | .7 | .7 | .7 |
| PPO Network | 1.8 | 1.8 | 1.8 |
| Cost Savings Resulting From Managed Care Features: | | | |
| Utilization Review Only | 4.0 | 4.0 | 4.0 |
| PPO Network | 15.0 | 15.0 | 15.0 |

Mr. NIEMIEC. One of the things, though, maybe to counter Mr. Butler's comment a little bit, any time you can eliminate something out of those extra costs and bring that premium down, you are going to do that. So, there are some natural tendencies there.

Anybody in Minnesota can pick up the telephone and call Blue Cross and Blue Shield directly. Agents do bring value to it, but that is the consumer's choice in whether they want to use that agent or not and incur the cost.

Mr. BUTLER. But I think it is very critical to understand that, as I mentioned earlier, there are really two or three elements in driving down the cost of that package. And managed care really gets at the claims portion of that, albeit it adds a little on the administrative side.

The other part then is, in fact, attacking the administrative costs through the economies of scale and through the extensive use of automation. And I can tell you that, in running the business, attacking each of those is extremely critical to us.

Senator DURENBERGER. The next question deals with the issue of managed care. The Children's Defense Fund, for example, was in here 2 days ago saying managed care does not save any money.

I am assuming that we would not be doing as much managed care in Minnesota as we are doing if we were not getting something for it. We are either improving the quality of health, getting more consumer satisfaction, or saving money; or all three of them. What is it?

And I suppose there are two ways to look at it. You can manage costs. You can hire a cost manager and call it managed care, but all they are doing is playing with your costs.

Or, you can move in the direction that Ms. Sailors was giving us from Florida where you are buying a different kind of a product: you are buying a healthier person, or you are buying a package, as she called it, rather than the hub caps, and so forth. What is the value in managed care?

Mr. NIEMIEC. If I could respond, Senator Durenberger. There are about as many factors in managed care as what you cited earlier in administrative expenses, so I am not going to do a real good job of detailing them all. But let me start off with an example which you are familiar with: State of Minnesota employees.

It has been an indemnity plan against HMOs for a long time with costs going up tremendously on the indemnity plan. A unique

arrangement where labor and management got together, negotiated on a benefits package and a network, put it out to bids.

We were fortunate enough to bid on it through our HMO, BluePlus, and introduced that several years ago. The rate increases for the last couple of years have been less than six percent.

Some consternation was introduced; mostly from the providers who, for one reason or another, were not included in the network. When it got to the employees, they largely accepted it because they had access to quality providers.

The thing about managed care systems is that they evolve. What might have been done in 1988 is not done in 1992 because you refine your networks, and, if there is a program that was applied to all providers, if you can later refine it so it only applies to the problem providers, you do that. You may exclude providers from your network.

So, a lot of this is very subtle that I do not think the consumer sees. But if it does not deliver value to the consumer and give them access, they are going to switch to a different health plan.

Senator DURENBERGER. Let me try to see if I can get at the next issue, which is, what is going to drive up the cost of health insurance in the small group market, and what is going to take it down?

As I understood both of you, you are a little shy of rating restrictions; you are certainly shy of community rating, and so forth.

And you are getting too much rating restriction; narrowing of the band, because a lot of so-called healthy young people are going to see an increase in their prices, their employers are not going to understand they; they are going to drop their insurance.

Mr. BUTLER. And I think it is important to understand that phenomenon that, as they drop, the average cost then goes up.

Senator DURENBERGER. Right.

Mr. BUTLER. But you have got less people then to spread that remaining costs over. You take out a little bit of costs, and you take out a lot of premium payments. So, as that happens, up goes the average costs. You then go through that process again.

Senator DURENBERGER. Right. And the other thing that contributes to that and is related is pooling larger groups. And then one or the other of you made that—your advice was stick with two to 25 rather than going to 50 or 100 because that, too, is going to exacerbate the problem.

Now, let me turn it around on the other side and say, even if we did all of that, how could we reduce the overall impact? I am presuming we are getting some benefit for some groups on pre-existing conditions. The older groups are getting some benefit.

There is somebody in this system that has got to be getting some benefit. If we wanted to get the problems minimized, I take it, the best way to do that is to do what big companies do, and that is, charge everybody in their company the same price all the way across the board. I mean, you go to a company that has 100,000 employees, they all pay roughly the same amount or get the same general benefit, do they not?

Mr. BUTLER. I guess I want to draw a distinction between what the employer asks his employees to contribute towards the cost of the health insurance. That is, quite often, the same per employee in a small case or in a large case.

Senator DURENBERGER. Right.

Mr. BUTLER. There is nothing about small versus large that pushes that issue in one direction or another. The issue then is, in fact, what do you do about driving down the average costs of the insurance, and, as we said earlier, we truly believe that managed care is the critical component as we go forward.

And I would note today that in our preferred provider organization plans—which, incidentally, we make available to firms with two employees—we have the same thing in place for our big customers as we have in place for our small customers.

And we will introduce more plans in this whole managed care arena in the small case market in the months ahead of us.

Today we have a cost differential from an indemnity plan to a preferred provider organization plan of approximately 15 percent, and the PPO plan is 15 percent cheaper.

The critical thing to me is that, in fact, our experience is bearing that out so that we have not only discounted the price, but it is working right.

And, as a result of that and our other experience in the larger case market with managed care, I am optimistic that we will be able to take another five or ten percent out of that cost base as we move further into even more managed care plans for the small employer market.

If we can get 20–25 percent out of that average cost, that is just an enormous step and very much offsets any increase that comes in the average costs coming out of the various rating restrictions and the various market reforms.

Senator DURENBERGER. Well, I am just trying to understand how the market works now. And I am presuming what you say about what is going to happen assumes that the insurance functions pretty much stay the same; that you have got 1,500 companies all trying to get some of this, some of that, some of the other kind of things.

Because, at least the presumption I make—and maybe I am wrong here—is that, let us say you had only a half a dozen companies, to really exaggerate the point, they would still want to get as much business as they could, would they not?

Would they not want to get into small group markets, as well as the large group markets, and would they, or would they not spread the costs of, let us say a community-rated small group over their larger book of business? They would not?

Mr. NIEMIEC. Senator Durenberger, if I could respond. I should not answer for any other company, since we are a larger carrier and we hopefully are going to be in the small group market for a long time, as we are in individual and all markets.

But I think one way to look at your question is that right now in the small group market you have the problem of people going in and out. You do not have anywhere close to universal coverage.

And if people are wanting to come into the insurance system when they anticipate a need, they have higher costs, and something gets taken care of.

Now, affordability is a problem, and, you know, the case was cited by Senator Riegle. Then you have this churning, and that is what is tending to drive the costs up.

Before actuarily you can really have a community rate that would work—because people are going to shop for the best price, and you have got problems with MEWAs—is you have to move towards universal coverage and you need subsidies.

Once you have done that, I think you could look at community rating. But the rating restrictions that are proposed by NAIC are significant and they would largely eliminate the abuses that are in the market right now and would make a significant step without destroying the market.

I think what you need to do is a year or two after you have implemented it, State-by-State, or however you do it, look at it and see, have you been able to bring more people in. Because that should be your goal.

If you have been able to do that, then maybe you can construct things. But if things are not working well, and there is still churning, then you had better figure out what the problem was: rating reform, or something else was the problem.

Senator DURENBERGER. Well, one of the things we should understand right up front that without some kind of a universal coverage mandate we are going to have to live with half the people going up and half the people going down, or something like that, and a bunch of people dropping out.

It is essential to have, at least, the employer must provide coverage kind of a mandate in order to make all of this work?

Mr. NIEMIEC. The employer is certainly key to this, and there are various proposals Blue Cross and Blue Shield has made. Our proposals involve large employers being required to contribute to coverage.

Smaller employers, because of affordability problems, is a tougher issue. You want to enable those smaller employers to do it, but mandating it right away is difficult. But it has been cited, and we know from our experience, small employers want to offer coverage.

So, I think you almost have to work it out. We have got an experiment going in Inoka County right now where we are truly going after the uninsured groups. We are not trying to get people to switch coverage, but target the uninsured groups.

And it is phenomenal, the experience we are finding; the barriers you have to overcome to get these people in. But I think they are achievable.

Mr. BUTLER. I think it is very important to understanding that mandating coverage does absolutely nothing about the cost of insurance.

The cost of insurance is a function of the claims and the expenses. And that is the thing that has to be addressed. And mandating merely puts an additional burden on employers who, today, cannot afford that burden. It is just not a solution.

Senator DURENBERGER. Well, if you do other things, it forces you in the direction of moving into some kind of grouping up in your purchase, or something like that, does it not? Trying to seek—if you were forced, as in the President's plan, to provide access to coverage, then you would have to go out and find the most economical plan, or the most beneficial plan, or the most efficient plan, or the lowest priced plan, or something like that.

Mr. BUTLER. Or go out of business.

Senator DURENBERGER. Right.

Mr. BUTLER. I mean, I think it is very important to understand that going out of business is a very real alternative—not a very attractive one to anybody.

Senator DURENBERGER. Right.

Mr. BUTLER. But it is a very real alternative to mandating anything on that small employer marketplace.

Senator DURENBERGER. And the other question is, where is the issue of the ERISA preemption and so forth in all of this, dealing with the reinsurance and with risk-pooling, and some of these kinds of issues, and how important has that become to moderating the impact, if you will, of what we propose to do with this bill?

Mr. NIEMIEC. Senator Durenberger, relative to S. 1872, small group reform, you want to have the States be able to regulate all the entities so that the rules apply to everybody. Otherwise, you are going to have people that can escape to something else and the younger, healthier groups are going to do that. And so, we have concerns that they will be built by the States and are strong enough.

I have additional concern with the HINs being talked about, where they would be regulated separately. And it is going to be much more confusing from a regulatory standpoint. The simple answer is: the same rules should apply to everyone who is selling in the small group market.

Mr. BUTLER. I think I would add to that by noting that the preemption would, in fact, eliminate several of the employer and insurance company mandates that are out there that drive the average cost up, so they are a part of the solution of driving the average cost up.

Senator DURENBERGER. I particularly appreciate, Mr. Butler, in your statement, your examples on the problem we would create if we go to gender-neutral and age-neutral issues, because there are fairly dramatic differences in both of those areas.

So, thank you both very much. Thank all the witnesses. The hearing is adjourned.

[The hearing was adjourned at 1:22 p.m.]

# APPENDIX

## Additional Material Submitted

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### Prepared Statement of Senator Christopher S. Bond

Mr. Chairman, I thank you for holding this hearing today on this very important subject and for the opportunity to testify. The crisis in health care which we face today demands reform. It is my hope that Congress will make health care reform its top priority when the Economic Growth package has been passed. The families, children, individuals and businesses who suffer under the current system cannot afford to wait.

I believe there is a growing consensus on a number of issues and it's time for us to get to work. Reforming the small insurance market is the first and one of the most important priorities and I commend the Chairman for his leadership in this area. Getting affordable insurance to workers in small businesses is a sizable step forward to getting our health care system on the right track. Eighty percent of the uninsured are tied to small businesses either as workers or their dependents. Clearly, this is the right place to start and the Chairman should be commended for recognizing this and leading us toward that end.

There are a long list of problems in our system that must be addressed and I support broad health care reform to address these varied and complex problems. But today, I am going to focus on one set of those problems.

One very large problem that we must address is the huge administrative costs of our health care system. Everyone would agree that a solution must be found that reduces these costs and the burden they are placing on our health care system and the ability of people to afford it. A study published in the New England Journal of Medicine estimated that we spend between $96 and $120 billion each year in administrative costs. These costs are escalated by the unwieldy inefficient paperwork-blizzard billing system that has evolved in this country.

We also have a system that has allowed some unscrupulous insurance companies try to only insure healthy people. To me, we don't have any need for insurance companies who run when someone gets sick. Last week, I held a series of roundtable meetings to discuss this mess we have in health care. I heard from a family whose child was born with hydrocephalus which has resulted in serious health problems for their son. Their son is now 14 years old but nine years ago their family went bankrupt due to their son's costly medical costs because they can't get any company to insure him.

Another couple in the St. Louis area has a son that was born with a defective heart valve. The birth of their son was not covered because the father was forced to find new employment 5 months into his wife's pregnancy and the new plan wouldn't pay because it was a pre-existing condition. Their second insurance plan that they have been forced to purchase under their previous employer's plan under COBRA just ran out the first of February and their son still has a series of surgeries that he must undergo if he is to live.

We also heard from a man who had colon cancer 4 1/2 years ago and cannot find an insurance company who will insure this condition now even though his cancer is in remission.

But to fix these problems, we need a system to compel insurers to to make some fundamental changes in the way they do business. To accomplish this, I am proposing legislation to establish minimum standards that health insurance plans must meet to become a "Qualified Plan." These standards are very simple and straightforward.

Qualified Plans would:

(1) Lower Administrative Costs—Require Less Paperwork. Insurers would use a new paperless computerized billing and data exchange system that will cut wasteful costs from the excessive paperwork and hassle that results from the existing claims and paperwork nightmare that none likes.

(2) Guarantee Acceptance. Insurers could not exclude individuals on the basis of their medical condition.

(3) Guarantee Renewability. Insurers would be prohibited from unilaterally cancelling insurance.

(4) Limit the Variation in Premiums. No longer could an insurer drastically hike premiums when a person develops a very expensive illness.

(5) Eliminate the Pre-existing Condition Waiting Period. Insurer would not be able to exclude coverage for any medical condition if that individual had had continuous coverage under a previous insurance plan.

(6) Limit Out of Pocket Costs. In short, insurers would have to fully protect consumers from costs exceeding $3000 or 10% of their income in a year.

My legislation would create an independent Insurance Benefits Assessment Commission to oversee the implementation of the Qualified Plan program and make recommendations to the Secretary for additional standards for Qualified Plans that would further deduce administrative costs, protect consumers, and seek ways to implement effective long-term management of health costs.

Under this proposal, insurers would be subject to a 25 percent excise tax on the gross premiums of any insurance plans which do not meet these consumer protection standards and participate in the program to reduce administrative costs.

Both goals—lowering administrative costs and extending the basic consumer-protection standards to Qualified Health Insurance Plans—are efforts which I believe are achievable this year and must be priorities for reform. Both goals must be achieved whether you subscribe to a "Pay or Play" proposal or a market-based proposal—these are problems in the system that must be fixed. Creating an electronic billing system and the resulting administrative savings, plus savings we could get from the added ability to reduce billing fraud through such a standardized system, are estimated to be somewhere between $50 and $80 billion. The fact that the consumer-protection standards must be applied should be self-evident from the specific instances we all have heard from our constituents.

Shank you again, Mr. Chairman, for holding this hearing and for the opportunity to share my concerns and my proposal with you. I hope to be able to work with you and the members of the Committee in getting such a plan enacted.

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PREPARED STATEMENT OF SENATOR DALE BUMPERS

Mr. Chairman, I thank you for allowing me to appear and to testify today. I am here in two roles: as Chairman of the Senate Small Business Committee and as a member of the Senate Appropriations subcommittee which funds preventive health programs. These jobs, I hope, bring a slightly different perspective to the Committee.

In recent years, efforts to improve Americans' access to health care have focused on small business. This is understandable because of estimates that the majority of the 34.6 million Americans without health insurance have some ties to the work force, and that the uninsured are concentrated in small firms, especially those with fewer than 25 employees. As large as these numbers are, they do not reflect the vast number of insured persons who fear that their insurance will be canceled or premiums will become totally unaffordable.

Mr. Chairman, I recently held a Small Business Committee hearing in my home State on this topic and heard firsthand the importance of increasing the ability of businesses to help provide health care coverage for their workers. While it is appropriate to concentrate on small business in trying to improve health insurance coverage, the remedy should not create more problems than it solves. Quite honestly, the small business community feels under attack because of allegations that, as a whole, they are uninterested in providing health coverage for their employees. They have been accused of neglecting their workers and of effectively shifting the costs of care through high insurance premiums to those big businesses which do offer health insurance to their employees.

Let me share a couple of stories that I heard from my constituents at the field hearing in Little Rock. Chuck Blair of North Little Rock, Arkansas, owns an auto repair shop with four employees. Providing his employees with insurance is very important to him. Mr. Blair's health insurance premiums have increased 315 percent from 1983 to today. The increase from 1991 alone is 74 percent. He has controlled his premiums—if a 74 percent increase can be called cost control—by being an ag-

gressive shopper. He is concerned that another increase in premiums will mean he simply can't offer coverage to his employees.

Another witness, Terry Scott of Mt. Ida, who has cystic fibrosis and, ironically, is an insurance broker. When he left his job at a large insurance company to begin working as an independent insurance broker, he cost his health insurance coverage. Although he describes his illness as a mild form of cystic fibrosis, his medical bills are very high. In February of 1989, his lung collapsed and his medical bills were $36,000, a sum which exceeded his entire year's income. Mr. Scott, as an independent insurance agent, has exhausted all avenues in trying to find coverage for himself. In reflecting on the health care problem more generally than his own situation, he testified: "As an independent insurance agent, I sit across the table from people every day, and I have to look them in the eye and say, 'I cannot get anyone to cover you.'"

Small business people overwhelmingly want to provide health insurance coverage for their employees and themselves. In most cases, small business employees and their families are friends or even family members of the business owner. Unhappily, the barriers to finding that coverage are often insurmountable.

I applaud the Chairman and other members of the Committee for their leadership in crafting S. 1872, the Better Access to Affordable Health Care Act. It is a very important step in our incremental progress toward comprehensive health care reform. Minimum Federal standards for health insurance sold to small employers, as well as limits on excluding individuals from coverage and on cancellation of policies due to claims experience or health status, are very important for small firms. And the limits on annual premium increases for small employers' health plans will be very important to struggling new businesses.

And I especially compliment the Chairman for increasing to 100 percent and making permanent the tax deduction for health insurance costs of self-employed individuals. I have introduced legislation to increase the deduction since the 100th Congress, and I am pleased this provision has been included in S. 1872. This discrimination against America's 14 million or more self-employed citizens cannot be tolerated any longer.

These reforms—important as they are—do not come free. One of the issues of concern to me is that we still do not have good information about what small-market reform will cost. The experts tell us that for businesses with pretty good health records, costs will go up. For those businesses with a history of health care use or employees with potential or actual high bills, the price of insurance, if it has been available at all, will go down. We have to be careful that the cost does not increase so much that even more businesses will be priced out of the market. And Mr. Scott's and Mr. Blair's experiences suggest that these reforms may not be enough. Mr. Scott, who is a self-employed person, will benefit from the increased tax deductions, but he still might not be able to find a policy he can afford. Mr. Blair is already on the edge, and it is not clear that the controls on premium increases alone will be enough to help him.

The legislation you have introduced to improve the availability and affordability of health insurance for small businesses will be, as you have noted, only one step in the progress toward comprehensive reform. A number of other approaches will be debated, and I believe that debate will be a healthy thing for our political system. Many of us are so frustrated with the present system that we are on the verge of agreeing to major surgery.

Cost containment is absolutely critical for small businesses that are being crippled by health insurance premium increases. It is also one of the most difficult challenges we face. Americans want the best care that American medicine has to offer, without waiting, without rationing, and at a reasonable price. For most of us, the best care is available without rationing, but the price is not reasonable and millions of our fellow citizens have no access to care. I believe there is a greater awareness among the people that some compromises will have to be made to provide quality care to all citizens at a price that is not crippling to our economy.

One provision of S. 1872 is particularly appealing to small businesses, and that provision is grants to States to establish employer health insurance purchasing programs. These group buying programs have had some good successes and I think we need more of them. By banding together, small businesses can act like big businesses in negotiating with insurance companies and health care providers. The State funds in this bill will not only enable small businesses to negotiate better but will allow them to reduce administrative costs, which are a significant part of premiums. Differences in administrative costs among businesses of different sizes is startling. For those with one to four employees, administrative costs average 40 percent of claims, while in businesses with more than 10,000 employees, administrative costs are only 5.5 percent.

I would also suggest that if reform of the health care system is to be incremental, first consideration should be given to improving health insurance coverage for pregnant women, infants' and young children. This Committee has an outstanding record of leadership in extending Medicaid coverage to pregnant women and children, so I know your commitment in this area is strong. I am pleased that the standard package described in S. 1872 includes prenatal and well-baby and child care. The benefits of prenatal care and well-baby care—both in human and economic terms—are so overwhelming that these populations should be given priority during consideration of health care reform.

As you know, the Appropriations Committee has traditionally funded a number of preventive health programs where the public program operates at least as effectively, if not more effectively, than the private sector effort. Most obvious is the childhood immunization program, where delivery of immunizations to school-age children through the public sector immunization program has shown a benefit-cost ratio of 14 to 1. I would think that the benefits of immunization would convince all insurers to cover immunizations, but they have not. Again, I urge the members of the Committee to remember the need for coverage for important preventive services when you attempt to define a minimum benefits package.

I have digressed about the need for prenatal and well-baby care and preventive care because I believe this time of great change in the health care delivery system provides us an opportunity. While we must solve the problems of access for the millions of uninsured Americans, and we must implement comprehensive cost containment efforts, we can also seize this chance to change some of the incentives in the American health care system. We need to place a greater emphasis on preventive care for all Americans; my experience is with those programs that serve children, but preventive care must be emphasized for all.

For the last 2 years I have secured Federal funding for a school-based health insurance demonstration project in two small communities in the Arkansas Delta region. This project funds school nurses to do basic health screenings for all students in all the schools in these two communities, a model that has been expanded in many other communities in the form of school-based clinics. This project is different, however, because it also finances health insurance coverage for those children who are neither Medicaid-eligible nor covered by their parents' health insurance. Therefore, if the child's health screenings uncover a chronic or acute health problem, there is no problem getting care for that child. In fact, in the very first round of screenings some major health problems were detected in some children, and they are now receiving treatment for those previously undetected problems. This treatment will probably save some lives and will certainly avoid major health care costs later on.

This project is new, and it is much too early to draw any conclusions about it. However, the program directors are very excited about what the project can teach us about case management or managed care in an entire community, as well as the lessons it can offer about a community-wide health education effort. And I am intrigued about whether the school setting is an appropriate locus not only for delivering care but also for financing it. I know that many believe the time for demonstration projects and evaluations is over and the time for action is here, but I think this project might serve as a good model for improving insurance coverage—and therefore access to care—for children.

Mr. Chairman, I think we are in agreement that we need to do more to ensure that every man, woman, and child is medically secure. I do not think there has ever been a problem in my lifetime that is as universally agreed on where the solutions are as universally disagreed on.

Mr. Chairman, I appreciate your focusing on small businesses. Unless this Nation has a radical change of mind, health care access in the near future will still depend on employer-sponsored health insurance. The single most important factor in determining if we open our high-quality health system to more people is whether small businesses can afford it.

Thank you for this opportunity to appear.

## Prepared Statement of Bruce Butler

**Introduction:**

Good morning, my name is Bruce Butler. I am president of Managed Care and Employee Benefits for Small Business at The Travelers, a Fellow in the Society of Actuaries and a Member of the American Academy of Actuaries.

The Travelers is one of the largest commercial insurers for small businesses, with a small case premium volume of $1.1 billion in 1991. We insure over 40,000 small employers with over 787,000 covered employees and dependents. About 30% of our business is written through associations, such as Business Council of New York or Kansas and Missouri Chambers of Commerce. We insure employers in all 50 states.

The Travelers is committed to the small business market. We have established a distinct organizational structure - virtually, a separate company, if you will -- that focuses solely on the small business customer. Our products, distribution systems, administration, and customer service are geared toward that specific customer base. To back up our commitment and to recognize the important role that agents play as employee benefit consultants and administrators, in 1991, The Travelers purchased Travelers TeleBrokerage, Inc., a telemarketing facility located in Illinois, to provide us better access to that critical distribution channel. And we will shortly be launching a major advertising campaign -- again, focused specifically at agents and the small business customers they serve.

**General Points:**

While small group market reform is a central feature of effective, fundamental reform of our health care system, there are a number of other principles we believe should guide any effort to develop a national health care policy.

(1) Successful reform of the health care system should include both private and public sector responsibilities. The private sector must ensure a stable, competitive, cost efficient market for health care coverage and be willing to propose and support legislation designed to accomplish those objectives.

For its part, the public sector must fulfill the commitments it has made in funding health care programs for the poor and elderly, and in expanding programs to ensure that all who are entitled to this protection are included. To help reduce costs and facilitate the efficiency and innovation of the private market, government should act to remove and resist the impulse to impose new impediments to affordable insurance and low cost care. The most pervasive examples of these barriers today are state mandated benefits and anti-managed care laws.

(2) The employer-based system continues to offer the most efficient and flexible vehicle for health care coverage and should be retained. The combination of public programs and employer-based health insurance covers over 85% of the population. It offers the opportunity to extend coverage to those currently uninsured. For the majority of the employed population, the employer based system permits the use of a variety of individual and business tax policies to encourage innovation. And it provides the purchasing leverage through managed care and other strategies needed to help keep system costs down.

(3) Managed Care offers the best opportunity to contain costs and assure quality in a market-based system and in government programs. Use of data to catalogue and assess the efficacy of medical treatments, case management for the most

efficient access to appropriate medical care, organization of hospital and provider networks to improve efficiency and reduce administrative costs -- Managed care has evolved in a short time to take many forms and offer many options. Managed care techniques should be applied to public sector programs like Medicare and Medicaid to help contain costs and to reduce cost shifting. The continued development, innovation, and implementation of managed care should be encouraged, and should be a part of any comprehensive health care policy proposal.

(4) Employers and employees should be the primary source of health care financing. Government should encourage and facilitate the use of private dollars to pay the health care costs among those portions of the public who do not qualify for public sector support. Tax supported financing should be limited to the segment of our society without adequate resources.

Other reforms we encourage include malpractice tort reform; funding for technology assessment, practice patterns and outcomes research; continuity requirements for large, insured and self-insured employers; study on how best to control fraud and abuse in health care; and efforts to promote reduction in administrative costs and improvement of data collection.

**Problems in the Small Group Market**

Over the past few years, dramatic increases in medical care costs and several trends in pricing, underwriting, and renewal have contributed to instability in the small group market, and illustrate the need for a return to sound business practices among carriers who operate in that market. These trends include:

(1) Cost of medical care. Increasing cost of provider services and technology, increasing utilization of services, and cost shifting from the public to the private sector have continued to adversely impact medical care costs and as a result, health insurance costs.

(2) Tough underwriting. Faced with steadily increasing health care costs, many insurers turn to underwriting for their competitive edge. Too many small cases fail to make the cut when insurers are forced to eliminate the less attractive risks.

(3) Low first-year pricing. In highly competitive markets, getting a foot in the door may lead to very low first year prices. The problem arises when those low first-year prices necessitate significant renewal increases.

(4) Post claim underwriting. Providing health insurance coverage until someone gets sick is not good public policy. It is an inappropriate way to operate in the small group market.

(5) Cancellation at renewal. Either explicit non-renewal, or price increases which would encourage non-renewal(i.e. "get lost" pricing), have become one of the all-too-prevalent practices which add to the instability of the small case market.

**Proposals**

A number of proposals have been offered to address these small case market issues. Among those which we believe offer no solution and should be rejected by the committee are:

(1) Play or pay. Play or pay is a derivative of national health insurance and will lead to a fully public, government subsidized program. It will cost small businesses jobs and money, force individuals currently covered by private insurance into a public plan, and increase federal spending as larger subsidies become necessary to cover the costs of a public plan.

(2) Employer mandates. An earlier version of play or pay, employer mandates would impose debilitating costs on small business and cause the loss of jobs. Projections have shown that employer mandates would not only have no effect on reducing the ranks of the employed uninsured, but would, in fact, eliminate jobs.

(3) Community rating. Under community rating, a carrier would charge the same premium rate for all employees in an area without distinguishing for the cost differentials associated with age, gender, or health status. We feel such artificial price controls are a big mistake.

The fact is that health care costs do vary by the age and gender of those who are insured. A recent report by the actuarial consulting firm of Milliman and Robertson provides the following statistics:

| Age/Sex | Annual Medical Claims |
|---|---|
| Nationwide Average | $1,460 |
| Males under 30 | 710 |
| Females under 30 | 1,690 |
| Males age 42 | 1,265 |
| Females age 42 | 2,030 |
| Males age 62 | 3,980 |
| Females age 62 | 3,825 |

Community rating would effectively "tax" younger workers to subsidize health care costs associated with older workers. Besides being unfair, community rating would undermine the concept of risk pooling whereby all the pool participants contribute according to the expected risk they present to the pool -- everyone pays their fair share, not everyone pays the same.

Community rating would have the following adverse impacts on the small employer market:

A. The majority of employers will see rates rise. Rates are clustered at the lower end. The Travelers estimates that removing age distinction alone would raise rates for 60% of employers.

B. Rates will be further out of reach of the uninsured. Those least able to afford insurance tend to be younger. Community rating is Robin Hood in reverse, taxing the younger employer groups getting started to pay the costs for well established firms with mature workers.

C. The employer's incentive is removed. Employers should encourage a healthy lifestyle and safe work environment. Managed care, and the cost savings it can achieve, works best when the employer is a motivated advocate for cost containment. Community rating will take away the incentive to promote healthy life styles and cost effective programs.

D. Employers will drop plans/self-insure. Lower cost employers will drop plans rather than subsidize the rates paid by higher cost groups. The average insured rate will rise when they drop out. Representative Rostenkowski's bill recognizes this concern and, in fact, prohibits groups of 50 and under from self-insuring.

E. Insurer capacity/competition will shrink. The financial volatility of moving to community rates will cause some carriers to withdraw from the market. Finally, it is important to note that these proposals ( (1), (2), (3)), do nothing to drive down cost --- rather, they drive it up!

As an alternative to these proposals, the insurance industry has offered a package of small case market reforms. I would like to emphasize two points about small group market reforms: (1) They require significant, in some cases stringent, restraints on insurance company activities in the small case market, and (2) They have been developed jointly by the industry and regulators. They are promoted and endorsed by the insurance industry. As such, small group market reform represents a major commitment on the part of Travelers and others to address one of the most pressing issues in the health care policy debate: how to expand and guarantee insurance coverage to those now most likely to lack the opportunity to purchase it through their employer: small business employees.

In addition, the small group reform proposals designed and endorsed by the insurance industry would help stabilize the cost of small group health insurance, and ensure continuity of coverage among small business employees who change jobs.

These reforms include:

(1) Guaranteed issue. Insurers would be required to accept all small business cases which seek insurance.

(2) Guaranteed continuity. Insurers would be required to renew all business.

(3) Pre-existing condition limits. Insurers could not refuse coverage once initial pre-existing illness periods were satisfied. Coverage would not be lost through job change.

(4) Rate increase/pricing restrictions. Insurers would be required to keep annual and renewal rate/price increases within specified, limited boundaries known as rating bands.

(5) Reinsurance pools. High risks would be spread through participation by small group underwriters in a reinsurance pool.

(6) Public sector responsibilities. The public sector would be encouraged to help reduce costs in the small case market by curtailing or eliminating mandated benefits, and by removing regulatory and legislative impediments to managed care.

Travelers has pursued enactment of these and similar reforms in a number of states, including our home state of Connecticut. Travelers is working with others in the industry to gain enactment of small case market reforms in fifteen states within the next two years. We will submit the list of target states for the committee record.

**The Bentsen/Durenberger Bill (S 1872)**

In addition to several other health care reform provisions, the Chairman's bill (S 1872) adopts many of these small case market reforms, albeit at the federal level. While we have not endorsed S 1872 as currently written, and prefer enactment of small group reforms at the state level, we must emphasize that the Chairman's bill offers a far more desirable approach to health policy reform than employer mandates, play or pay, or national health -- all of which proposals we explicitly oppose. We have identified a number of concerns, and offer suggested modifications, entirely in the spirit of cooperation. Here are the areas most in need of review:

(1) Rating bands in S 1872 are too tight. We agree that rating bands should be applied, and have proposed them in our small case reforms. However, the limits must be broad and flexible enough to permit profitable small case underwriting, and to ensure continued participation in this market by private insurers. We recommend rating bands and procedures closer to those contained in the industry model provision.

(2) The size of the group covered in S 1872 should be reduced. The underwriting and rating problems in the small group market are not prevalent for groups of more than 25 employees. Including larger groups under the required market reforms will add significantly to the cost of doing business in that market.

(3) The managed care provisions would prejudice types of service, and limit innovation. Definition is unclear. Federal standards are too specific and detailed. There is preferential treatment for certain forms of managed care. These are neither necessary nor desirable in this market at this time.

(4) The purchasing corporation concept needs further study and more careful design before being implemented. While the purchasing group concept offers the possibility of cost savings through efficiencies and market leverage, market experience with currently organized associations and purchasing groups ought to be examined for real rather than anticipated benefits. Also, we recommend against unfair preferential treatment for small business purchasers organized into purchasing groups. Finally, careful review needs to be given to the market experience and solvency issues that have arisen in connection with MEWAs and other health insurance group purchasing arrangements.

Mr. Chairman, thank you for the opportunity to offer these remarks to your committee. I'd be happy to answer any questions.

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PREPARED STATEMENT BY SENATOR JOHN H. CHAFEE

Thank you, Mr. Chairman. I commend you for convening today's hearing. The rising cost of health care and the increasing number of uninsured individuals in this country is a growing concern. The time has come for Congress to enact legislation which will slow the growth in health care costs and increase access to critical health care services for those who are uninsured.

The legislation before the Committee today has considerable bipartisan support. In fact, many of the provisions in the Chairman's bill are also included in a proposal introduced by myself and 22 other Senate Republicans. My only concern about the bill under consideration today is that it doesn't do enough to address the problems that millions of Americans now face when it comes to health care.

Over the past decade we have heard considerable debate about reforming our health care system. Some contend that we should look to other nations such as Canada or Germany to solve our problems. Others believe that it is the responsibility of employers to provide health insurance to their employees and their families. Still others feel that the Federal government is already too much involved in our health care system and that by using market forces, our problems could be solved. The time has come to stop debating the issue and take action to help individuals and businesses better afford basic health care services.

In looking at proposals offered by the Chairman of this Committee, the Senate Democratic Leadership, the Administration, and the proposal offered by the Senate Republican Health Task Force, one can see a number of areas in which, if not included in all proposals, could be grounds for an agreement. Those areas include insurance market reform, the formation of small business purchasing groups, encouraging managed care, encouraging the availability of primary and preventive care services, preemption of costly State mandated benefit laws, reducing administrative costs, strengthening our community health centers, creating equity in the tax code, State experimentation, and hopefully medical liability reform.

Getting an agreement on those issues is a tall order, but believe we can do that and more. And I believe that such a proposal can be enacted this year. There are however, two obstacles to achieving that goal. First, those who want too much: those

who refuse to budge from their ideal of how our health care system should be, and second, those who underestimate our ability to enact significant reform in our system. We can go further than the proposal under consideration today, and we can start with the ten issues that I just mentioned.

I hope that our efforts will not be derailed by either camp. We have an opportunity to enact legislation this year, which if not guaranteeing health insurance for each and every American, would go far toward that goal . . . if not reducing the amount of money we spend on health care, will slow the rate of growth. Only enactment of legislation will make a difference to our citizens, not lofty debate on our vision of the perfect health care system. Let's not miss that opportunity.

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PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

Two weeks ago, I said I thought the President's health speech as the "end of the beginning" of health reform. Now that we have heard from every quarter, it is time to finish the "air war" and start the "ground war" of health reform.

Thank you, Mr. Chairman for beginning the action phase of this process by initiating these hearing on insurance reform.

There are three very good reasons why this Committee should immediately report out S. 1872 and push it through the Senate floor without delay.

First, what health reform needs now is not more emotion, but forward motion. We have a system which has a host of difficult and interrelated problems. They are showing up in the pain and uncertainty of millions of Americans families and businesses. We don't have a lot of financial resources or political capital to put against our problems. So that means we've got 10 years of hard work to do to turn that around. Why delay our departure any further?

We can either try to pacify people with gimmicks, or take genuine steps to solve their problems. This bill is a genuine step toward greater access and lower costs, without compromising quality of care. We should take it.

Second, the American people benefit far more from a bill that passes than a package that sells.

We have all the packages on the table: Mitchell-Kennedy-Rockefeller-Riegel; Chafee-Dole; the President's; and others. What major reform do they have in common? Small group insurance reform. That should be the end of the argument.

But I have heard people from both sides argue, "We can't pass any of the parts, we need to hold out for our whole package." In practical terms that means we'll probably end up with stalemate rather than action, because short of capitulation, there is no hope for a bipartisan package.

This bill will do good for people, point the system in the right direction and build momentum for the next step.

Third, we are going to have to choose between politics and progress. There is simply no way we can hope to take on a problem of this magnitude with one hand tied behind our backs. No "Republican plan" is going to solve it; no "Democratic plan" will solve it. Neither the Congress or the President alone is going to make a dent.

Let's walk before we run. Republican and Democrats. The Congress and the President. We all basically agree on the need for insurance reform and the value of this bill to meet that need.

That's why I introduced the first small group insurance bill in 1990. That's why I introduced S. 700 in 1991. And that's why I'm the lead Republican on Senator Bentsen's bill.

Let's put our emotion and our packages and our politics aside and do something helpful for people.

Let's pass this bill and set an example that health reform can proceed when we work together.

Attachments.

FLOOR STATEMENT BY SENATOR DAVE DURENBERGER—BENTSEN-DURENBERGER HEALTH CARE BILL

Mr. president, I am pleased to rise today to join the distinguished chairman of the Finance Committee in introducing the "Better Access to Affordable Health Care Act." This is a historic first step toward making this a healthier Nation and I urge all my colleagues to join us in this step.

Ways and Means Chairman Dan Rostenkowski is introducing a somewhat similar bill on the House side today. I want to thank him and Chairman Bentsen for incorporating many of the ideas and specific provisions I developed in S. 700, the Amer-

ican Health Security Act, and in S. 89, legislation I have introduced that provides full deductibility for health premiums of the self-employed.

Mr. President, 1 year ago almost to the day, I introduced S. 3260, the Small Employer Health Benefit Reform Act. My goal was to introduce greater equity and stability in the market for small group health insurance through a set of minimum Federal standards. I subsequently re-introduced that legislation on March 20, 1991 as S. 700, the American Health Security Act.

I am extremely pleased that much of "Better Access to Affordable Health Care Act" is patterned after S. 700. The bill my friend from Texas and I are introducing today will establish minimum standards for health insurance sold to companies of two to 50 full-time employees. Insurers in this market will no longer be able to exclude individuals in a group from coverage or cancel policies due to claims experience or health status.

As in S. 700, this bill will significantly limit the variation in premium rates between small employers. It will also constrain annual premium increases for small group health plans to the underlying trend in health care costs, plus 5 percent. States will be required to guarantee the availability of insurance to all small employers in the State, but they will have flexibility on how best to do so.

Insurers participating in the small group market will be required to offer two standard health plans. The specifics of these plans differ from those included in S. 700, but the goal is the same: to make less expensive coverage available to small employers. Finally, up to 15 States will be given grants of up to $10 million each to finance the development of insurance pooling arrangements among small businesses.

Mr. president, the benefits of this legislation are not restricted to the employees of small companies. For the self-employed, this bill will permanently extend the tax deductibility of health insurance, from 25 percent to 100 percent. I have long advocated this change, most recently in S. 89.

An exciting feature of this bill for many hard-pressed families is the portability requirement dealing with pre-existing conditions. This bill ensures that employees will no longer be locked into a particular place of employment by a pre-existing health condition. So long as coverage does not lapse for more than 3 months, group health insurance—including self-insured plans—may not impose a pre-existing condition exclusion more than once for the same condition. Health problems that were diagnosed or treated during the previous 3 months cannot be excluded from coverage for more than a single 6-month period.

Mr. President, the real challenge we face in trying to expand access to health insurance coverage to all Americans is controlling the cost of health care. Our bill will establish a national commission—with members appointed by the President and confirmed by the Senate—to advise Congress and the president on strategies for reducing health care costs.

In addition, more funding will be allocated for research on health outcomes, targeted specifically to treatments for conditions that significantly affect national health expenditures. Measures are also included to encourage further expansion of managed care plans.

I would say at this point that I do have a serious problem with one particular section of Chairman Rostenkowski's bill. In an effort to control prices charged by medical providers, he recommends that by 1994 we put in place a system that pays all providers the same price for all services. This is not a proposal I can support.

Mr. President, it was my privilege to serve as a vice-chairman of the U.S. Bipartisan Commission on Comprehensive Health Care—the Pepper Commission. During our many meetings and public hearings, we saw graphic examples of the failures in our current system of financing health care. We heard devastating testimony from uninsured people.

These were not all poor people, Mr. President. Many of them were employed and would be considered middle class by today's standards. At least they would have been had their medical expenses-not pushed them to the brink of poverty.

Why were these middle class Americans uninsured? There are many reasons. Many worked for businesses—usually small ones—that either did not offer, or had ceased to offer, health benefits. While they wanted to buy insurance to protect their families, they either could not afford it or they were denied coverage due to some pre-existing health condition. Some were medically uninsurable. Some were so seriously ill that their medical expenses had exceeded their health plan limits, and they were denied additional coverage.

Take the case of Kurt Homan and his son Lee, from Plymouth, Minnesota. On February 23, 1988, Lee was diagnosed with leukemia. Because Kurt had recently changed jobs, the diagnosis came just 5 days prior to the effective date of health insurance benefits that he had signed his family up under. Consequently, private

insurance has not been available to pay for the several hundreds of thousands of dollars in medical expenses incurred by Lee since his diagnosis.

Mr. President, access to health care in America should not depend on where you work. That is just not right. But each day that passes, that's becoming true across the country.

American workers rely on the private health insurance market for protection from the spiraling cost of getting sick in America.

For employees of larger companies this financing system works pretty well. Health insurance protection is relatively affordable and, in general, no one is denied coverage because of their health status.

However, for people who are employed by companies with fewer than 50 workers—the fastest growing segment of the labor market—the private health insurance market is a dismal failure. And we're not talking about just a few workers here. This group amounts over half the work force in some States. In Minnesota 40 percent of the workforce, 750,000 people work for firms of fewer than 50 employees. Small business, by and large, is where America works. That's why this bill is so urgently needed and why it can have such a dramatic impact.

Small employers seeking to purchase coverage for their workers are forced to choose among a confusing array of very expensive products. Large employers have no trouble finding coverage. In addition, they have the option to self-insure if they desire and thereby escape costly State-mandated benefits in their health plans. Obviously, self-insurance is not a realistic option for employers of fewer than 50.

To make matters worse, insurers engage in rating and coverage practices that introduce great inequity and instability into the health insurance market for small businesses.

Mr. President, the current regulatory framework for health insurance is weak and inconsistent across States. Under it, insurers may refuse to sell policies to anyone and can cancel policies unilaterally. They can selectively deny or restrict coverage for specific employees or an employee's dependent because of a pare-existing health condition, or charge exorbitant risk premiums.

Small group health insurers often low ball the initial premiums offered to an employer to get the business, and shortly thereafter raise the premiums by huge amounts. They also selectively market to younger, healthier groups.

This practice—which certainly has no place in an industry that is supposed to be in the business of insuring risks—is known as creaming, or cherry picking. Together with the other practices I've just described, creaming results in tremendous instability and turnover among small employers seeking to obtain more affordable coverage.

Mr. President, let bring this down to ground level by talking about the experience of several firms in Blaine, Fridley, and Anoka, Minnesota, prosperous communities north and west of the Twin Cities, within minutes of each other.

An accountant with a small firm watched his premium go up 30 percent 1 year 50 percent the next, putting the price out of reach.

A beauty shop with nine employees can't get any health insurance because they don't have the minimum number to qualify as a group.

A sporting goods store with three employees: no group insurance available, individual rates prohibitively expensive.

An advertising company watches it's premiums climb year after year and then gets canceled: no notice, no explanation.

These are just 20 examples of hardworking people, like people we all do business with everyday, who are victims of this system. Multiply this by thousands businesses and millions of workers nationwide and you've got an idea what we are up against.

Mr. President, the job of reforming the American health care system will be a huge undertaking. We have 35 million uninsured. We have health care costs climbing at rate that is undermining the fiscal health of businesses government and families alike. We have a health care delivery system that is inefficient and doesn't respond to many of our basic needs.

But this is where we begin. Insurance reform is the key first step toward a fairer, less inflationary and more efficient health care system.

There will be some, Mr. President, who will shy away from this proposal because it is not "comprehensive" enough. Democrats may think passage of this bill slows down their larger plans. Republicans may hold back because they want see the President's plan. To all of them I say "How are we ever going to agree on the whole if we can't agree on any of the part?"

This bill is a concrete step we can take this year. I hope we won't succumb to the legislative disease of making "the good" the enemy of "the best."

Mr. President, there is bipartisan support in both houses for virtually all of the provisions of this legislation. Chairmen Bentsen and Rostenkowski have given us a golden opportunity to begin a course toward a healthier America.

Let's put aside our party labels and our presidential politics and do something for people who need help.

Let's embark together toward a healthier future for our people with this legislation.

Attachments.

## *THE DURENBERGER "THIRD COURSE" HEALTH REFORM AGENDA*

We need to structure health reform to **repair the weaknesses** of the current system while we **leave its strengths intact**. Here are the bills and ideas I have put forward to accomplish our goal of a healthier America by the Year 2000. (Those included in the President's plan, in whole or in part, are marked with an asterisk *. )

***Small Group Insurance Reform (S 1872 Bentsen-Durenberger)**

Make affordable, reliable insurance coverage available to small business workers and their families at the workplace by 1) defining a basic mimimum insurance policy, 2) require that it be offered to all companies, 3) prohibit underwriting policies that exclude or price gouge consumers, and 4) cut out unnecessary paper work and administrative costs.

***Health Tax Equity**

Provide a 50% tax credit to small businesses for insuring their workers and 100% deductibility for the self employed, financed by limiting deductibility of business health premiums by other businesses. This further narrows the gap between what insurance costs and what people can afford.

***Medical Liability Reform (S 1836)**

Our current medical liability system doesn't reward victims and doesn't prevent mistakes. We need to get these problems out of the back logged courts and into settings where victims get what they deserve and hospitals and doctors can learn from their mistakes.

***Medicaid Restructuring**

Find more effective ways to improve public health by allowing states to experiment with community-based delivery systems; expand coverage to include "near poor" mothers and children who need services but don't currently qualify.

***Medicare Restructuring**

A group of reforms, including physician payment reform, merging Part A and Part B, moving to outcomes based practice guidelines, long term care and a catastrophic benefit, to put medicare back on a sound financial base and update it to reflect current needs and problems.

**Medical Technology Reform**

Reduce market incentives to buy technology to win customers rather than provide quality of care; set up structure to facilitate proper capital planning at the local level.

***Reaffirmation of Healthy Values**

Personal responsibility and prevention, not federal programs, are the key to a healthier American future.

**Redesigning the Practice of Medicine**

We waste billions on over-head and bureaucracy that we desparately need to expand access for the uninsured and for long term care. We need to define standards for medical efficiency and reward efficient providers and those who buy services from them.

## THE BETTER ACCESS TO AFFORDABLE HEALTH CARE ACT OF 1992

In October 1990, Senator Dave Durenberger (R-MN) introduced S.3260, the Small Employer Health Benefit Reform Act. His goal was to introduce greater equity and stability in the market for small group health insurance through a set of minimum federal standards. The bill was re-introduced in March 1991 as S.700, the American Health Security Act. In early 1991, Senator Durenberger introduced S.89, a bill that would provide full deductibility for health premiums of the self-employed.

Senator Durenberger, Senator Lloyd Bentsen (D-TX) and Congressman Dan Rostenkowski (D-IL) worked together to develop S.1872, the Better Access to Affordable Health Care Act. The legislation incorporates the key ideas and provisions of S.700 and S.89.

The following are the highlights of S.1872:

** The tax deduction for health insurance costs of self-employed individuals would be increased permanently from 25 percent to 100 percent beginning in calendar year 1992.

** Minimum standards would be established for health insurance sold to employers with two to 50 employees working at least 30 hours a week.

** Individuals in a group cannot be excluded. Policies cannot be canceled because of claims experience or health status.

** Premium variations would be restricted for factors such as health status, claims experience,length of time since the policy was first issued, industry or occupation. Rating bands would be established.

** The General Accounting Office would report to the Congress on the impact of the rating restrictions on the price and availability of insurance to small employers.

** Annual premium increases would be tied to trends in health care costs as measured by the increase of the lowest premium charged to an employer plus 5 percent.

** There will be several options for guaranteeing availability of insurance to all small employers in a given state.

** Insurers offering coverage to small employers would offer at least the Standard Benefit Package and the Basic Benefit Package.

** The standards called for in the bill would be developed by the National Association of Insurance Commissioners and approved by the Secretary of Health and Human Services.

** Violators of the standards would be subject to a federal excise tax equal to 25 percent of premiums received on policies sold to small employers. Some exemptions would apply.

** An individual with a health problem who changes jobs without a lapse in health coverage of more than three months would generally be protected from any pre-existing condition exclusion under the new employer's health plan for those services covered in the employee's previous plan.

** All group health insurance would be prohibited from excluding coverage for pre-existing conditions for more than one six-month period. The exclusion would apply only to conditions that were diagnosed or treated during the three months prior to enrollment.

** A program of federal certification for managed care plans and utilization programs would be established. States would be prohibited from applying certain laws that restrict the development of managed care plans and utilization review programs to federally certified plans. Standards for federal certification would be developed by the Secretary of Health and Human Services, in consultation with the Health Care Cost Containment Commission.

** The 11-member Health Care Cost Containment Commission would advise Congress and the President on strategies for reducing health care costs, including administrative costs. The Commission would make recommendations on the development of a federal certification process for managed care plans and utilization review programs.

** Authorization for outcomes research would be increased annually from $110 million in 1991 to $275 million in 1994. Clinical treatments or conditions that significantly affect national health costs would be targeted.

** Medicare benefits would be expanded to cover several preventative care services, a proposal similar to S.1231, the Medicare Preventative Benefits Act of 1991, which was introduced by Bentsen and Rostenkowski.

**SUMMARY OF THE BENTSEN HEALTH CARE BILL**

**PROBLEM: SKYROCKETING INSURANCE COSTS FOR SMALL BUSINESS WORKERS**

**The Congressional Budget Office reports that 80 percent of the uninsured are in families with at least one worker, and the majority of these are in small businesses. Many small employers would like to provide health insurance coverage but find it unaffordable. In 1990, business spent an average of $3,000 per employee on health insurance -- an amount that has been increasing over 20 percent annually in recent years.**

THE BENTSEN BILL: The tax deduction for health insurance costs of self-employed individuals would be increased permanently from 25% to 100% beginning in calendar year 1992.

A new grant program would be established to assist up to 15 states in developing small employer health insurance group purchasing programs. $150 million would be authorized for grants up to $10 million per state for fiscal years 1992 through 1994. The funds could be used to finance the development of cooperative arrangements among small businesses who wish to pool resources in purchasing insurance. Funds could be used for administrative costs including marketing and outreach efforts, negotiations with insurers, and performance of administrative functions such as eligibility screening, claims administration and customer service. The Secretary of HHS would be required to conduct an evaluation of the impact of these programs on the number of uninsured and the price of insurance available to small employers.

The Secretary of HHS would be required to report to the Congress on the feasibility and desirability of requiring acceptance of Medicare payment rates from private insurers covering small employers.

**PROBLEM: "CHERRY PICKING"**

**Some small employers have had difficultly buying or renewing health insurance coverage because some insurance companies "cherry pick" -- they only offer coverage to companies with young, healthy employees or in certain industries. They also write policies to exclude employees who have a preexisting health problem, or cancel coverage once claims are submitted, effectively denying coverage to those who most need insurance.**

THE BENTSEN BILL: Minimum standards would be established for health insurance sold to small employers, defined as those with 2 to 50 employees working at least 30 hours a week. Insurers could not exclude individuals in a group from coverage and could not cancel policies due to claims experience or health status.

Variation in premiums for small employers would be restricted for factors such as health status, claims experience, length of time since the policy was first issued, industry or occupation. Rating bands would be established such that the ratio of the highest to lowest premium charged to a small employer with similar demographic characteristics for similar benefits could not exceed 1.8 for the first three years the new requirements were in effect (a rating band of plus or minus 20% around the average), and lowered to 1.6 thereafter (a rating band of plus or minus 15% around the average.)

The General Accounting Office would report to the Congress on the impact of the rating restrictions on the price and availability of insurance to small employers. The report would include the Comptroller General's recommendations regarding the elimination of variation in rates due to health status factors, age and sex composition of groups and other factors.

Annual premium increases for small employer health plans would be tied to the underlying trend in health care costs, (as measured by the increase in the lowest premium rate charged to small businesses by the insurer) plus 5 percent.

States could choose among several options for guaranteeing availability of insurance to all small employers in the state. These include requiring that insurers "guarantee issue" (sell insurance to any small employer who seeks it) and establish a voluntary reinsurance program, guaranteed issue with mandatory participation in a reinsurance program, and programs that allocate high-risk groups among insurers, with and without opt-outs for insurers that guarantee issue.

Insurers offering coverage to small employers would offer at least two benefit packages. (1) The Standard Benefit Package would cover unlimited inpatient and outpatient hospital services, physician services, preventive care limited to prenatal and well-baby care, well child care, pap smears, mammograms, colorectal screening and limited inpatient and outpatient mental health services. (2) The Basic Benefit Package would cover inpatient and outpatient hospital services (including emergency services), physician services, and preventive services.

Standards reflecting these requirements would be developed by the National Association of Insurance Commissioners (NAIC) and approved by the Secretary of HHS. If the NAIC does not act promptly the standards would be developed by the Secretary of Health and Human Services.

Insurers violating standards would be subject to a federal excise tax equal to 25 percent of premiums received on policies sold to small employers. Insurers in states having a regulatory

program approved by the Secretary would be exempt from the tax, as would insurers in other states that the Secretary of Health and Human Services certifies as meeting federal standards.

**PROBLEM: WORKING AMERICANS ARE SUBJECT TO "JOBLOCK"**

**According to a New York Times/CBS poll published in late September, three in ten Americans said they or someone in their household have stayed in a job they wanted to leave because they feared losing health benefits.**

THE BENTSEN BILL: An individual with an ongoing health problem or "pre-existing condition" who changes jobs without a lapse in insurance coverage of more than 3 months would generally be protected from any pre-existing condition exclusion under the new employer's health plan for those services covered under his or her previous health insurance plan.

All group health insurance including self-insured employer plans would be prohibited from excluding coverage for pre-existing conditions for more than one 6 month period. The exclusion would only apply to conditions that were diagnosed or treated during the 3 months prior to enrollment.

PROBLEM: RISING HEALTH CARE COSTS

**Health care costs consume 12% of GNP, a percentage projected to increase to 17% by the end of the decade -- a trend that the President's budget director has described as "unsustainable".**

THE BENTSEN BILL: A program of federal certification for managed care plans and utilization programs would be established. States would be prohibited from applying certain laws that restrict the development of managed care plans and utilization review programs to federally certified plans. Standards for Federal certification would be developed by the Secretary of HHS, in consultation with the Health Care Cost Containment Commission described below.

A Health Care Cost Commission would be established to advise Congress and the President on strategies for reducing health care costs. The 11-member Commission would report annually on trends in national health spending. The Commission would be required to report on the impact of administrative costs on health care spending and make recommendations for minimizing such costs, including development of uniform billing requirements for use by all insurers and providers. The Commission would make recommendations on the development of a federal certification process for managed care plans and utilization review programs.

Authorization for outcomes research would be increased from $110 million to $175 million in FY 1992, to $225 million in FY 1993, and to $275 million in 1994. New guidelines would be targeted at clinical treatments or conditions that significantly affect national health expenditures.

**PROBLEM: PREVENTION BENEFITS ARE NEEDED**

**The Medicare program, like many private health insurance plans, provides only very limited benefits for preventive health care services. It is time to refocus health care coverage toward preventive services that can avoid the need for more costly treatment by identifying medical problems earlier.**

**THE BENTSEN BILL: Medicare benefits would be expanded to cover a number of preventive care services including cancer screening and influenza immunizations. This provision is identical to S. 1231, the Medicare Preventive Benefits Act of 1991 introduced earlier this year jointly by Senator Bentsen and Congressman Rostenkowski.**

**PRELIMINARY ESTIMATES: Preliminary estimates put the total 5 year federal cost of the bill at $10 billion: $7.4 billion in revenue lost from increasing the tax deduction for the self-employed and $2.6 billion in new outlays for the expansion in Medicare benefits.**

American Health Security Act of 1991

What does this legislation (S.700) do?

- o Establishes important, new consumer protection standards for private health insurance plans sold to small businesses and self-employed individuals.

- o These requirements will help make private health insurance more widely available and affordable.

What would these new standards accomplish?

- o These standards would make the conditions under which private health insurance policies are sold much fairer for small employers and their employees. There are also provisions which would guarantee availability of lower-cost benefit packages (MEDPLANS) than are currently allowed on the market in most states.

- o For instance, insurance companies:

  - could no longer refuse to issue policies to small groups or self-employed individuals for reasons such as poor health status or working in a high-risk occupation.

  - could no longer cancel health insurance contracts unilaterally, leaving groups unprotected.

  - could no longer exclude individual employees from coverage under an employer's group plan, just because the employee had poor health, or had a dependent child in poor health.

  - could no longer establish excessively long waiting periods for coverage of employees who have pre-existing medical problems.

- o In addition, insurance companies would be required to:

  - Set their premium levels in a fairer way under "rating" standards

  - Disclose to the general public their methods for setting premium levels, and for increasing premiums over time.

- o Most importantly, insurance companies would be required to make <u>available</u> to all small employers, two packages (known as MEDPLANS) designed especially to meet the needs of small businesses. This means that small businesses will have a lower cost insurance product available to them, no matter where in the country their business is located.

What are the important features of the MEDPLANS?

- o First, there are two different plans. One is a "Core" benefit plan that covers essential hospital, medical and prenatal care services.

- The second is a "Standard" plan. This is an enriched benefit plan that includes all the core benefits, plus supplemental benefits for mental health and chemical dependency services.

- MEDPLANS are exempted from State mandated benefit laws that have been estimated to add 20-30 percent to premium levels. Therefore, we expect MEDPLANS to be less expensive than most other insurance products currently available to small employers.

How much will MEDPLANS cost?

- The premiums for MEDPLANS will vary by market and for different buyers. This is because medical care costs vary around the country and because the demographic characteristics (such as age or sex) of groups will vary. These and other factors can cause premiums to vary, even for identical benefit packages.

- However, we estimate that the Core MEDPLAN could be priced at about $900 to $1200 per year for individual coverage. At $900 per year, the monthly cost would be $75. We estimate that the Standard MEDPLAN could be priced at about $1200-$1600 per year. At $1200 per year, the monthly cost would be $100.

- These estimates compare very favorably with the national average cost of private health insurance benefits offered by employers, which in 1989 was about $1,800-$2,000 for individual coverage.

States have traditionally regulated the so-called "business of insurance". Does S. 700 federalize this regulatory responsibility?

- S. 700 would establish nationally uniform consumer protection standards for health insurance products sold to small businesses and self-employed people.

- However, S. 700 permits States to maintain their traditional role of regulating this market, if they enact State laws that accomplish the same degree of consumer protection.

- In any State that failed to enact such protections, insurance companies selling products in that State would be required to abide by the federal rules.

- Practically speaking, this means that if all 50 States enact comparable consumer protection standards, then there would be no direct federal regulation of insurance companies' practices.

- Lastly, S. 700 does not override or in any other way intrude upon the States' traditional role of regulating financial solvency and related standards for insurance companies.

It appears that insurance companies would face a very high financial penalty if they violated the consumer protection rules. Is the level of the penalty fair?

- S. 700 says that an insurance company that violates the rules would be liable for a federal excise tax penalty of 20-percent of gross accident and health premiums for small group contracts in force during a taxable year.

- This may seem high, but it is not high relative to the "economic value" to an insurance company of engaging in the practices that would be prohibited under S. 700. It is highly profitable to an insurer to deny or cancel coverage to higher-risk groups and individuals because the insurer is able to keep claims expenses down simply by avoiding the risk of enrolling such groups or individuals.

- Consequently, the level of the tax penalty must be high enough to deter these practices.

Why is it important to reform private health insurance?

- First, buying a health insurance policy is much more than just a convenient way to budget for potential health care expenses. A health insurance policy provides vital economic protection to individuals and families should someone have a serious accident or illness. It helps protect wages, savings and other personal resources from being wiped-out due to costly medical bills.

- Second, except for the Medicare and Medicaid programs, most Americans obtain this protection by buying private health insurance. And most private insurance is purchased through policies sold to employers who offer it as a fringe benefit to their employees. About 63% of the labor force or 158 million people are covered by employer-based health benefits.

- Unfortunately, there are over 30 million people not yet protected through either our public programs or private health insurance. And importantly, 20 million of these are workers (and their dependents) employed in small businesses, such as doctor's offices, restaurants, retail shops or construction crews.

- Since so many Americans obtain their health care protection through the workplace by buying private insurance products, it is essential that this market work in a fair way.

Why are so many of the uninsured concentrated in employment in small businesses?

- There are a number of reasons that many small businesses do not or cannot obtain group health insurance policies that their employers can buy into.

- The main reason is the costliness of policies, especially for firms that have narrow profit margins or employ mainly lower-wage employees. For instance, the current federal minimum wage is $4.25 per hour or $8,840 per year. The average cost of a health insurance policy in 1989 was about $2,600 per year. If an employer offered such a policy to a minimum wage employee, it would represent a 29% increase in payroll cost. This is simply too much for some companies to afford. Nationwide, health benefits as a percent of payroll is about 9.3%.

- Second, small employers often have difficulty buying health benefits for their employees because insurers can refuse to sell them coverage for any reason whatsoever. Even if the insurer agrees to sell coverage to the employer, it can still refuse to cover specific employees.

- Third, even if an employer carries coverage, insurers can cancel the health plan without recourse, or impose significant (20, 30, 40-percent or more) premium increases.

- Lastly, although the high cost of medical care, and consequently health insurance, is of concern to all of us, small firms have these other difficulties in buying private health insurance that larger employers do not have.

- Generally, larger companies are able to create their own self-insured plans. Even if they rely on private insurance, they are not subjected to the underwriting and other discriminatory practices that are prevalent in the small-group market.

Statement of Senator Dave Durenberger
Introduction of - S. 700
"American Health Security Act of 1991"
March 20, 1991

Mr. President, it goes without saying that the American people are dissatisfied with their health care. We have problems of access: one in eight Americans have no health insurance protection, public or private. We have problems with costliness: insurance premiums and benefit costs continue to rise at alarming rates.

As Co-chair of the Pepper Commission, I can say that the problems of our system are agreed upon and well understood. The challenge now is how to span the gap between where we are today, and where we want to be next year and ten years from now.

Today, I am introducing legislation which I hope will be the first plank in a cross-walk which will bridge the inadequate system we now have, to the improved system the American people want, and deserve.

I am introducing along with Senator McCain and Senator Wallop the "American Health Security Act of 1991". This legislation will help address the issue of America's uninsured by adding essential consumer protection standards into the private health insurance market as it relates to employees of small businesses.

I invite my colleagues on both sides of the aisle to join me in cosponsoring this legislation. This is a bipartisan issue and I believe I have crafted a solution that has great bipartisan appeal.

Today, over 30 million Americans lack health insurance protection. They are vulnerable not only to the high costs of medical care, but their very economic security can be threatened by the expense of a major illness.

Significantly, most of the uninsured are not jobless. It has been estimated that 70 percent of the uninsured, or about 20 million people, are either employed workers or the dependents of workers. Further, three out of every four working uninsured persons are employed in small businesses, with the biggest gap in health insurance coverage occurring in companies with fewer than 25 employees.

Why is this the case? Is it because small employers do not want to offer this important fringe benefit to their employees? No! The fact is that many small firms are interested in securing these benefits, but when they go to the private insurance market to get them, they run into serious obstacles.

Insurers can and do refuse to sell insurance contracts if they don't want to accept the employer's group (for any reason), and can cancel contracts unilaterally. They can and do

selectively deny or restrict coverage for specific employees or an employee's dependent child (with pre-existing medical conditions). They can and do charge prohibitive risk premiums.

In addition, insurers often "low-ball" the premiums offered to an employer in the first year, and once they've hooked the account, raise the premiums abruptly in later periods by 20, 30, 40 percent or more.

They also market carefully to attract primarily lower-risk groups. Selecting low-risks is known as "creaming" or "cherry-picking".

These practices foster enormous instability and turnover, or "churning", among small employers who try to buy health benefits, and discourages many employers from even trying.

These are not just run-of-the-mill sharp business practices that we can deplore, but shrug our shoulders over. They have important and negative societal consequences.

For instance, in the Pepper Commission field hearings, we heard testimony from individuals who could not leave dead-end jobs because they had a sick child and could not risk losing their health care coverage.

Reverend Oakes of West Virginia told us about how he was fired from his job when his wife was diagnosed with cancer because his employer feared that the company's health benefit plan premiums would skyrocket or that the plan would be terminated for everyone.

So the question for us as legislators is what can we do to help small employers do the job they'd like to do.

If we want to help expand health benefits through the small business workplace, then we must act to stabilize this market. We must have consumer protection standards that are clear and effective, that insurers can comply with, and whose fairness all small employers can rely upon.

The legislation I am introducing, the "American Health Security Act of 1991", will tackle these problems by setting uniform standards nationwide that require the following:

- o Guaranteed issue of policies.
- o Limits on insurers' ability to impose coverage restrictions due to pre-existing conditions.
- o Guaranteed renewability of policies.
- o Restrictions on experience rating and limits on annual increases in premiums.

In addition, the bill includes two benefit packages designed expressly with the needs of small businesses in mind.

Although these are federal standards, this legislation permits States to regulate these practices provided the State laws are at least as rigorous as the federal standards.

The number one problem for small employers is the costliness of private health insurance. The high cost of medical care is a major part of this and an issue we cannot continue to neglect.

However, another important cost factor is the trend in state legislatures to mandate that health insurance policies include

all manner of costly benefits that are not essential to most people's basic health insurance needs. Yet these state mandates can raise premium costs an estimated 20-30 percent.

To address this problem, I propose to require insurers to make available to small employers, two specially-tailored benefit packages called MEDPLANS. One is a core plan, the second is an enriched standard plan. However, both are exempt from state benefit mandates and will give small employers a more affordable alternative.

We estimate that the core MEDPLAN could be marketed at a premium of about $900 - $1,200 per year or as low as $75 per month. The standard MEDPLAN could be marketed at about $1,200-$1,600 per year, or as low as $100 per month. This is much lower than the average cost of $2,000 per year for benefit plans now on the market.

I would be the first to acknowledge that these are not ideal health plans, - but, they are ideal income security plans. And that is the main issue for employees who currently get no insurance protection.

Mr. President, if these reforms are enacted, it will be a watershed event in the evolution of the private health insurance industry in this country. Can the private health insurance industry rise to the challenge?

The industry itself acknowledges the need for the basic reforms contained in this legislation. If we work together, there is a real opportunity to preserve the choices, diversity and potential for innovation that resides in the private sector.

I, for one, believe that insurers can thrive financially by "doing good," so long as all carriers must abide by the same rules. If even one company can undercut these rules, our efforts to perfect America's unique system of mixed public and private benefits will be doomed.

Mr. President, it has been suggested to me that this boils down to two simple tests for the industry:

1) The MARKET TEST - Can insurance carriers give us what we want at a price that serves the insurer's necessary economic goals of market share and profit margin?

2) The SOCIAL TEST - Can insurance carriers give us what we want, - namely access to financial protection, affordable premiums and coverage for the health care services we most need?

The course that we currently are on in the private health insurance market will most assuredly make it fail both these tests. Some carriers will inevitably fail on the market side due to competitive pressures and poor management. However, I'd like to focus now on why many companies are failing the social test.

Insurance plans compete to give buyers what they want, BUT ONLY WITHIN THE LIMITS THAT WILL PRODUCE ACCEPTABLE FINANCIAL MARGINS TO THEM AS BUSINESSES! The very practices companies must engage in to survive and compete on economic terms, are fundamentally at odds with our social objectives of broad-based affordable, comprehensive coverage.

Companies can't survive if their premiums aren't competitive. Therefore, they deny coverage to high-risk groups and individuals to keep their premiums down. The facts are that in today's market, risk selection is a much more powerful tool

and generates much greater competitive advantages to companies than does the much harder task of managing people's care and keeping their claims expenses down. It is this dynamic that we must stop.

Mr. President, the industry is in a crisis. It is facing a severe loss of public confidence in its ability to play a viable role in the future. Unless we act now to create a level playing field, the future ability of insurers to provide us with the financial security and services we need will be in grave jeopardy.

And my solutions are geared toward solving the social problems, not towards protecting the status quo in the private insurance industry, nor in the regulatory framework that has allowed it to evolve into what it is today!

The challenge for me and others who share these concerns is to put a new framework together that better meets our social needs.

In closing, Mr. President, as I said at the beginning, this is merely the first plank in building a crosswalk to a new order in our health care system. This new order must be a system where protection against the high cost of getting sick is seamless. By that, I mean that there must be no gaps left in the future between private and public programs for individuals to fall through.

The "American Health Security Act of 1991" cannot and will not do the whole job of closing the existing gaps in health insurance coverage. We must also redesign our major public programs like Medicare and Medicaid to achieve seamless protection for all regardless of age, employment or economic circumstances. To this end, I will be introducing major restructuring proposals for these programs later this session to achieve universal access for all Americans.

In addition, we must reexamine the $40 billion in tax subsidies that underlie employer-based health benefits. It is incumbent upon us to make sure that public subsidies of this magnitude support only those health benefit plans that meet social objectives of equity and efficiency. These are large undertakings. But if we are to have a socially just approach to meeting people's basic health care needs, we must tackle these issues. Mr. President, I ask unanimous consent that the complete text of this bill and a section-by-section summary be printed in the Congressional Record. Thank you, Mr. President.

American Health Security Act of 1991

Office of Senator Dave Durenberger

Section-By-Section Summary

A bill to amend the Internal Revenue Code of 1986 to impose an excise tax on insurance companies not meeting certain requirements with respect to health insurance benefits provided to small employers.

SECTION 1. TITLE

SECTION 2. FAILURE TO SATISFY CERTAIN STANDARDS FOR HEALTH INSURANCE PROVIDED TO SMALL EMPLOYERS

SECTION 5000 A.

- o Insurers must satisfy certain mandatory product offering, coverage and rating standards in selling health insurance contracts to small employers.

- o Failure to meet one or more of these standards during a taxable year shall make the insurer liable for an excise tax penalty equal to 20 percent of gross premium income on accident and health insurance contracts issued by the insurer.

- o Secretarial discretion on applying the tax penalty is permitted where:

  - insurer did not know or exercising reasonable diligence would not have known the failure existed, and

  - failures are corrected within 30 days, or

  - if failure was due to reasonable cause.

SECTION 5000 B.

This section describes mandatory product offering and guaranteed issue (of contracts) requirements.

- o Guaranteed issue of contracts: No eligible small employer can be denied issuance of a health insurance contract except for the employer's failure to achieve minimum employee participation rates, where applicable. There is a separate (delayed by 18-months) effective date solely for this requirement, to permit States to enact appropriate enabling legislation for reinsurance.

Mandatory Product Offering: MEDPLANS

- o Insurers marketing any health insurance products to small employers must make available (but employers are not required to purchase) a dual product offering known as MEDPLANS, described below. These two products must be priced consistently with the standards employed by the insurer in pricing and marketing their other products in the small group market, and with the requirements of this Act.

- o MEDPLANS are exempt from state benefit mandates. This preemption does not exempt from state benefit mandates other health insurance products marketed to small employers.

| BENEFITS | CORE MEDPLAN | STANDARD MEDPLAN |
|---|---|---|
| Deductible single/family | $500/1000 | $500/1000 |
| Out-of-pocket limit single/family | $3,000/6,000 | $3,000/6,000 |
| Hospital Services (IP/OP) | 20%/80% (EE/ER) | 20% |
| Surgical Services (IP/OP) | 20% | 20% |
| Physician Services (IP/OP) | 20% | 20% |
| Diagnostic and Screening Services (IP/OP) | 20% | 20% |
| Prenatal care | 20% (No deductible) ********** | 20% (No deductible) |
| Mental Disorders Inpatient | | 30 days/50% |
| Outpatient | | 25 visits/50% |
| Chemical Dependency Disorders Inpatient | | 30 days/50% |
| Outpatient | | 25 visits/50% |

SECTION 5000 C. SPECIFIC CONTRACTUAL REQUIREMENTS

This section sets standards for coverage, rating, disclosure, and recordkeeping.

- o Limits on preexisting medical conditions: Any limitation on coverage may not extend beyond 6 months after the initial issuance of coverage. This limit can apply only if the preexisting condition manifested itself during the 3-month period prior to issuance of coverage (aka "look-back" provision). No further waiting period for the preexisting condition can be imposed under any circumstances (such as change of carrier, or change to a different plan through switching jobs), unless an individual has had a break in coverage in excess of 120 days.

- o Guaranteed renewability: Contracts must be renewed at the election of the small employer, unless the contract is terminated for cause, such as non-payment of premiums. Contracts cannot be canceled due to adverse claims experience.

- o Rating requirements:

    - Acceptable premium ranges are defined within classes of business and between classes of business.

- Within class range: Premiums must be within 80-120% of the average rate (aka index rate) of the class.

- Between classes range: If an insurer has two or more classes of business, the average (or index) rate for any class cannot be more than 20% above or below the average (or index) rate for any other class.

o Exceptions: The Secretary may develop different ranges, as appropriate, for insurer's who do not underwrite premiums based on health status or claims experience and who offer policies on an open enrollment, basis.

o Annual rate change limitation: Within a class, rate increases on existing contracts are capped at the level of rates charged to new businesses, with adjustments for changes in a group's coverage and/or case characteristics.

o Disclosure and recordkeeping: These are rules requiring disclosure in sales materials of how premiums are set, the extent to which they can change, and the class into which a contract would fall.

Further, insurers must maintain at their principal place of business detailed descriptions of rating factors and procedures. Insurers must file annually with the Secretary, a qualified actuarial certification that their rating practices are based on commonly accepted actuarial assumptions and principles.

SECTION 5000 D. STATE COMPLIANCE AGREEMENTS

o The Secretary, at his discretion, may enter into agreements with States to permit State laws to govern instead of the federal standards.

- The CEO of the State must request such an agreement, and

- The Secretary must determine 1) that the State's standards will carry out the purposes of this Act, and 2) that the State's standards will apply to substantially all small-employer health insurance contracts issued in the State.

o Regardless of the above, the mandatory policy offering known as MEDPLANS cannot be waived.

o Separately, even if a State does not obtain an agreement permitting State laws to carry out the purposes of this Act, the State may still enter into a separate agreement with the Secretary to make determinations of whether insurers are in compliance with the federal standards.

SECTION 5000 E. DEFINITIONS AND OTHER RULES

This section defines contracts, classes of business and class groupings, eligible employers and employees, permissible rating factors and other rules.

Important to note:

1) Exception for small insurers: Insurers who had less than $1 million in gross accident and health premium income during the preceding taxable year are exempt from the requirements of this Act for the subsequent taxable year (aggregation rules apply).

2) A small employer is defined as an employer who normally employed more than 1 but not more than 50 employees, and self-employed individuals as defined under section 401(c)(1) of the Internal Revenue Code.

3) Prohibited factors in determining rates (beyond the boundaries permitted within classes) include health status, prior claims experience, industry, occupation or duration since the date of issue of a policy. If geographic location is used, insurers may not use areas smaller than Census Bureau designations of metropolitan statistical areas and non-metropolitan statistical areas.

4) Effective date is upon enactment for all requirements except guaranteed issue. That requirement will not be effective until 18 months after enactment.

5) Transition rules permit rates on contracts issued prior to the effective date to exceed the premium ranges within classes and across classes for two years or the second renewal of a contract, whichever is earlier.

By Mr. DURENBERGER:

S. 3260. A bill to amend the Internal Revenue Code of 1986 to impose an excise tax on insurance companies not meeting certain coverage and rating standards with respect to health insurance provided to small employers; to the Committee on Finance.

SMALL EMPLOYER HEALTH BENEFIT REFORM ACT

Mr. DURENBERGER. Mr. President, I am today introducing S. 3260, the Small Employer Health Benefit Reform Act.

This legislation takes a number of steps to reform benefit content, pricing practices and coverage restrictions that currently make it costly and difficult for small employers to offer private health insurance benefits to their employees.

HEALTH CARE IRONIES

Mr. President, I had the privilege of serving over the past 2 years as a vice-chairman of the U.S. Bipartisan Commission on Comprehensive Health Care—the Pepper Commission. Along with 11 of my House and Senate colleagues—and 3 private citizens—I was reminded again of the frustrating complexities and ironies in America's health care system.

I was reminded that, by one set of definitions, America has a health care system that is unparalleled anywhere in the world.

We have, without question, the most doctors, the most specialists, the most hospital beds, the most access points per capita of any nation on earth.

And, without question, we have the most innovation—new technology, new procedures, newly funded outcomes research—even compared to those nations who have become our peers in other fields of economic or technological competition.

One indication of the unparalleled nature of America's health care system is the degree to which it is sought out by those sick and injured who come here from all over the world—and by the export of technology and other expertise to wherever it can be afforded.

TOO MUCH, YET TOO LITTLE

At the same time, Mr. President, health care in this country suffers from serious and fundamental shortcomings. Put simply, health care in America costs too much and, for millions of Americans, it delivers too little. With the high cost of health care in America, widespread availability does not translate into universal access.

The hard, cold reality, Mr. President, is that, without private health insurance or enrollment in public programs like Medicare or Medicaid, financial access to health care is outside the reach of all but the most affluent Americans. A simple illustration highlights this dramatically. In 1970, the average cost of a hospital admission equaled 12 weeks of work for a minimum wage worker. In 1988, it equaled 43 weeks of work for a minimum wage worker. Now this says a little something about the levels of the minimum wages. But the fact is, the rising costs of health care have, for the last decade, far outstripped growth in workers' earnings, even for those above the minimum wage.

And, another unfortunate reality is that more than 30 million of our citizens have neither health insurance or meet the restrictive age or income eligibility requiremetns for our public programs.

It is another sad truth, Mr. President, that health care financing in this country has evolved in ways that often ignores sound insurance principles, that fails to reward individual health and wellness, and the provides serious disincentives to hold down costs.

Rather than insuring against financial castatrophe in cases of serious accidents or illness, for example, health insurance has largely become a heavily subsidized payment mechanism for a broad range of health-related benefits.

In the process, both consumers and providers have become insulated from financial responsibility—eliminating normal legitimate market forces that help contain costs.

Meanwhile, Federal tax policies that provide unlimited deductions to both employers and employees have further reduced the role that a properly functioning market might play.

NEEDED: SYSTEMWIDE REFORM

Mr. President, these failings in America's health care system won't recede without fundamental, systemwide reform. In particular, assuring universal access to quality health care will not be possible without a fundamental attack on the primary barrier to access—cost. To restate my earlier generalization, Mr. President, health care in America simply costs too much and, for millions of Americans, delivers too little.

To address that concern, health care reformers have historically split into two camps—heading in two different directions.

One set of reformers—including the Pepper Commission majority—is pointed to the Northeast, toward Massachusetts. Their solution is largely based on mandating health insurance coverage as a fringe benefit provided by employers.

The second set of reformers is headed due North toward Canada. Their solution is a single payer system—simplistically, expanding Medicare or Medicaid to cover the entire population.

For reasons I won't detail here, both these solutions are flawed because they serve ultimately to rearrange payment responsibility without containing costs. They may even prove so inflationary that they worsen access to health care services because of unsupportable cost pressures.

A THIRD COURSE FOR REFORM

My response to this dilemma has been to chart a third course—premised on accepting that we have a diverse and partly privately financed health care system, but with personal determination to incite fundamental changes in the way it performs.

I should emphasize, Mr. President, that this third course ought not be viewed as a defense of the status quo. And, it ought not be viewed as being deferential to any of the principle actors in our current health care system—consumers, providers, employers, insurers, or Government.

This third course, for example, assumes much greater consumer, provider, and employer responsibility. It assumes future fundamental reforms in governmental programs like Medicare and Medicaid. And, it assumes a vastly different role for the Federal Tax Code—to reverse incentives and create a truer and more properly functioning market.

To initiate the fundamental reforms we so desperately need, Mr. President, I intend to introduce legislative initiatives in each of these areas: Private health insurance reform, Medicare reform, Medicaid reform, long-term care financing reform, and tax reform. The initiative I am introducing today—involving small group private health insurance reform—is the first in this series of proposals.

ENHANCED ROLE FOR THIRD-PARTY PAYERS

At the heart of the private insurance proposals—and at the heart of this third course I have chosen in health care reform—is an improved and more socially responsible role for insurers, or for what we have come to call third-party payers.

Traditionally, these intermediaries between health care consumers and providers were limited primarily to health insurance companies. But, in more recent years, they have also been joined by Health Maintenance Organizations, perferred provider organizations, and others who administer self-insurance programs, manage care,

broker services, and perform other intermediary functions in the health care delivery system.

Mr. President, my third course in health system reform may be our last opportunity to salvage a significant role for competing third-party payers in America's health care system.

This large sector of America's health care system has come under increasing attack in recent years for taking too big a share of America's health care dollar and delivering too little in return.

Many Americans find it unconscionable, for example, that 20 cents or more of every dollar spent on health insurance goes to advertising, agent commissions, design of competing benefit packages, and other administrative functions that have very little to do with either keeping people well, curing their illnesses, or healing their injuries. One recent study suggested these administrative costs go as high as 33 percent.

NOT DEFENSE OF STATUS QUO

So, Mr. President, my previously stated reservations about a single payer system of health care in this country ought not be characterized as a defense of the status quo—and, particularly, not characterized as a defense of the current role of America's health insurance industry.

If third-party payers, in other words, continue to be nothing more than collectors of premiums and payers of claims nothing more than agents to facilitate the transfer of large amounts of money, then I would agree with those who would collaspe their role into a single payer system like Medicare.

Medicare, after all, has very low overhead—very little is spent on administration' nothing is spent on advertising; there are no agents collecting commissions. About 97 percent of what we spent on Medicare actually goes to providing health care. Only 2 to 3 cents on every benefit dollar gets spent on administration and other nonhealth related services.

NEW FUNCTIONS FOR INSURERS

In my view, if private health insurers are to survive the next decade, they must invest in and adopt new, enhanced roles. What functions would justify the expense of continuing to pay for competing intermediaries between consumers and providers of health care? In my mind, the functions are those that make those intermediaries positive, contributing partners in our efforts to address the systemic problems of cost, access, and failures in the health care market. They include functions such as serious claims management, monitoring the utilization and quality of medical services, containing unnecessary expenditures, and other value enhancements.

MISPLACED INCENTIVES AND DIRECTIVES

Unfortunately, Mr. President, the current incentives, directives, and rewards in the health care system won't move any but the most progressive private insurers to adopt new and enhanced roles.

So, fundamental changes will be needed, Mr. President, in how third party payers are viewed, the roles they are required to perform, and the incentives and rewards they are offered.

In the process, it will be essential that we leave room for a healthy State of competition among these newly defined third-party payers. Our experience—under Medicare and CHAMPUS—has been that Government may not be the best place to direct the kind of true reform and changes in roles for third-party payers that is needed. But, Government can stimulate market conditions to help make sure that competition is for quality and value, rather than simply price.

I am not prepared at this moment, Mr. President, to prescribe the exact means by which all those changes should occur. But, through the various public programs we administer, through Federal and State regulation of third-party payers, and through the tax treatment of insurers and employer-based fringe benefits, we do have the means to get that job done.

SMALL GROUP REFORM PROPOSAL

Finally, Mr. President, I want to comment briefly on the first in the series of health reform proposals I intend to offer over the next year.

I am introducing today S. 3260, The Small Employer Health Benefit Reform Act of 1990. Its primary objectives can be summed up in two words, "fairness" and "stability" in what has been a highly unfair and volatile small group health insurance market.

Recently, the National Journal ran an excellent article titled "Sick About Health." On reflection, a more apt title, which would also have captured my own views, would have been "Sick About Health Insurance." It captured almost perfectly the litany of problems and inequities in the small-group insurance market that we were exposed to in numerous hearings conducted by the Pepper Commission, and that I personally am resolved to try and do something about.

The American work force looks to the private health insurance market for essential protection from the spiraling cost of getting sick in America. And increasingly, despite enormous Federal tax subsidies—approaching $48 billion a year for employer-based health benefits alone—the industry fails to deliver services to the very segment of the labor market that is growing most rapidly—people who work in companies that employ 50 or fewer individuals.

Or, to be more pointed, it does deliver some things. It can deliver reasonably affordable coverage if you are fortunate enough to work in a company that employs mainly younger, healthier, more highly paid employees. Or, if you are not any of those things, you can usually obtain coverage if you are hidden in a large employer group. The latter, however, may not even help you if the large group happens to consist of health care workers, a construction crew, restaurant employees, or other occupations judged to be higher risk, and therefore viewed by insurers with a jaundiced eye.

All too often, employers seeking to provide benefits are faced with a bewildering array of product choices. The choices offer distinctions without differences, except that because of the 700-plus mandates on policy contents enacted by State legislatures, all of the products are likely to be so elaborate and expensive they are beyond the financial reach of most small firms.

Unfortunately, the other elements these products frequently have in common are high administrative costs relative to benefits paid out, and minimal control of provider payments, assurances of quality care or consumer education. These latter areas present the greatest opportunity for insurers to provide truly valuable services, but they have yet to fulfill their potential

Further, insurers engage in certain rating and coverage practices that introduce great inequities and instability into the health benefits market for small employers. Under the patchwork quilt of current State laws, most are permitted to refuse to sell policies without recourse and to cancel them unilaterally. They can selectively deny or restrict coverage for specific employees or an employee's dependant child—with preexisting medical conditions—or charge a prohibitive risk premium.

In addition, insurers often low-ball the premiums offered to an employer in the first year, and once they've hooked the account, raise the premiums abruptly in later periods by 20, 30, 40 percent or more. They also market carefully to attract primarily lower risk groups. Selecting low-risks is known as creaming or cherry-picking. This practice, in concert with these other practices, fosters enormous instability and turnover, or churning among small employers who try to buy benefits, and discourages even more employers from even trying.

Mr. President, these are not just run-of-the-mill sharp business practices that we can deplore, but shrug our shoulders over. They have important and negative societal consequences. There are over 31.5 million Americans lacking protection against health care costs, and 75 percent of those are workers or live in the families of workers. Over one-half of uninsured workers and their dependents are affiliated with firms of fewer than 25 employees.

If we want to facilitate the expansion through the workplace of private insurance coverage to these men, women, and children, then we must act to stabilize this market. And in order to achieve greater stability, we

must have at least some minimum level of standards that are clear and effective, that we know insurers can reasonably comply with, and whose fairness all small businesses can rely upon.

To that end, my bill "The Small Employer Health Benefit Reform Act," would amend the Internal Revenue Code and make insurers who sell any contracts to employers who employ 50 or fewer employees, liable for a 20-percent excise tax penalty on gross accident health and premium income if they fail to abide by certain product offering, rating and coverage requirements. These standards require: Guaranteed issue of policies; limits on insurers' ability to impose coverage restrictions due to preexisting conditions. Guaranteed renewability of policies; restrictions on experience rating; and limits on annual increases in premiums on existing contracts, accomplished by drawing a link between those rates and rates charged to new business accounts.

Mr. President, these standards were carefully crafted in consultation with numerous experts in insurance and in small business problems. I believe they are achievable by the industry and will go a long way toward enabling small companies to voluntarily offer health benefits to their employees. I think many small firms want to offer benefits in order to complete for and attract workers. This legislation will help them to do so. Early next session, I will be offering a separate bill to address the complex problems of state mandates on health policies and to offer a core benefit package designed expressly for the small business market.

In closing, Mr. President, this will not solve the problems of financial access to health care for all of the 30 million-plus people who we know currently lack protection. But this bill is a long stride in the right direction. As I stated earlier, other solutions are needed as well and I plan to offer additional legislation next session reforming the design of our major public health financing programs.

In the meantime, I urge my colleagues to consider cosponsoring the Small Employer Health Benefit Reform Act, and I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objecton, the bill was ordered to be printed in the RECORD, as follows:

S. 3260

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

SECTION 1. SHORT TITLE.

This Act may be cited as the "Small Employer Health Benefit Reform Act of 1990".

This Act may be cited as the "Small Employer Health Benefit Reform Act of 1990".

SEC. 2. FAILURE TO SATISFY COVERAGE AND RATING STANDARDS ON HEALTH INSURANCE PROVIDED TO SMALL EMPLOYERS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to excise taxes on qualified pension, etc. plans) is amended by adding at the end thereof the following new section:

"SEC. 4980C. FAILURE TO SATISFY COVERAGE AND RATING STANDARDS OF HEALTH INSURANCE OF SMALL EMPLOYERS.

"(a) GENERAL RULE.—There is hereby imposed a tax on the failure of any person to meet at any time during any taxable year—

"(1) the coverage requirements of subsection (e), or

"(2) the rating requirement of subsection (f), or

"(3) the disclosure and recordkeeping requirements of subsection (h), or

with respect to any applicable accident and health insurance contract.

"(b) AMOUNT OF TAX.—

"(1) IN GENERAL.—The amount of tax imposed by subsection (a) by reason of 1 or more failures during a taxable year shall be equal to 20 percent of the gross premiums received during such taxable year with respect to all accident and health insurance contracts issued by the person on whom such tax is imposed.

"(2) GROSS PREMIUMS.—For purposes of paragraph (1), gross premiums shall include any consideration received with respect to any accident and health contract.

"(c) LIMITATION ON TAX.—

"(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the person on whom the tax is imposed did not know, or exercising reasonable diligence would not have known, that such failure existed.

"(2) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

"(A) such failure was due to reasonable cause and not to willful neglect, and

"(B) such failure is corrected during the 30-day period beginning on the 1st date any of the persons on whom the tax is imposed knew, on excercising reasonable diligence would have known, that such failure existed.

"(3) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a).

"(d) LIABILITY FOR TAX.—

"(1) IN GENERAL.—The person issuing the applicable accident and health contract with respect to which a failure occurs shall be liable for the tax imposed by subsection (a).

"(e) COVERAGE REQUIREMENTS.—

"(1) IN GENERAL.—The requirements of this subsection are met with respect to any applicable accident and health contract if, under the terms and operation of the contract, the following requirements are met:

"(A) GUARANTEED ELIGIBILITY.—No eligible employee (and the spouse or any dependent child of the employee ellgible for coverage) may be excluded from coverage under the contract.

"(B) LIMITATIONS ON COVERAGE OF PREEXISTING CONDITIONS.—Any limitation under the contract on any preexisiting condition—

"(i) may not extend beyond the 12-month period beginning with the date an insured is first covered by the contract, and

"(ii) may only apply to preexisting conditions which manifested themselves, or for which medical care or advice was sought or recommended, during the 6-month period preceding the date an insured is first covered by the contract.

"(C) GUARANTEED RENEWABILITY.—The contract must be renewed at the election of the eligible small employer unless the contract is terminated for cause.

"(2) WAITING PERIODS.—(1)(A) shall not apply to any period an eligible employee is excluded from coverage under the contract solely by reason of a requirement applicable to all employees that a minimum period of service with the employer is required before the employee is eligible for such coverage.

"(3) DETERMINATION OF PERIODS FOR RULES RELATING TO PREEXISTING CONDITIONS.—For purposes of paragraph (1)(B), the date on which an insured is first covered by a contract shall be the earlier of—

"(A) the date on which coverage under such contract begins, or

"(B) the first day of any continuous period—

"(i) during which the insured was covered under 1 or more other health insurance arrangements of the employer, and

"(ii) which does not end more than 120 days before the date under subparagraph (A).

For purposes of this paragraph, coverage shall not be treated as beginning before the close of any period described in paragraph (2).

"(4) CESSATION OF SMALL EMPLOYER HEALTH INSURANCE BUSINESS.—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, a person shall not be treated as failing to meet the requirements of paragraph (1)(C) if such person terminates the class of business which includes the applicable accident and health insurance contract.

"(B) NOTICE REQUIREMENT.—Subparagraph (A) shall apply only if the person gives notice of the decision to terminate at least 90 days before the expiration of the contract.

"(C) 5-YEAR MORATORIUM.—If, within years of the year in which a person terminates a class of business under subparagraph (A), such person establishes a new class of business which includes contracts within the class of business so terminated the issuance of such contracts in that year shall be treated as a failure to which this section applies.

"(D) TRANSFERS.—If, upon a failure renew a contract to which subparagraph (A) applies, a person transfers such contract another class of business, such transfer must be made without regard to any rating characteristic.

"(f) RATING REQUIREMENTS.—

"(1) IN GENERAL.—The requirements of this subsection are met with respect to any applicable accident and health insurance contract if—

"(A) the premium rate or rates under the contract are within the acceptable premium range, and

"(B) any increase in any premium rate under the renewal contract over the corresponding rate under the contract being renewed does not exceed the applicable annual adjusted increase.

"(2) ACCEPTABLE PREMIUM RANGE.—For purposes of paragraph (1)(A)—

"(A) IN GENERAL.—The acceptable premium range includes premium rates which not more than 120 percent, or less than percent, of the average rate.

"(B) AVERAGE RATE.—For purposes of paragraph (A), the term 'average rate' means 50 percent of the sum of—

"(i) the lowest premium rate, determined under the rating system for the ra

period which covers the contract, which may be charged by the person issuing the contract for substantially similar coverage to employers with similar case characteristics (other than risk characteristics), plus

"(ii) the highest premium rate which may be so charged.

"(C) RANGE MAY BE DETERMINED BY SECRETARY.—In the case of any class of business covering applicable accident and health insurance contracts—

"(i) with respect to which employers who are eligible are not, and have never been, rejected for coverage on the basis of risk characteristics as defined under section (j)(2)(B),

"(ii) to which business may not be involuntarily transferred from another class of business, and

"(iii) which is currently available for purchase,

the acceptable premium range with respect to such contracts shall be the range (determined in accordance with this subsection), if any, established by the Secretary.

"(3) APPLICABLE ANNUAL ADJUSTED INCREASE.—

For purposes of paragraph (1)(B)—

"(A) IN GENERAL.—The applicable annual adjusted increase is an amount equal to the sum of—

"(i) the applicable percentage of the premium rate under the contract being renewed, plus

"(ii) any increase in the rate under the renewal contract due to any change in coverage or to any change of case characteristics (other than risk characteristics).

"(B) APPLICABLE PERCENTAGE.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the applicable percentage is the percentage (if any) by which the premium rate for newly issued contracts for substantially similar coverage for an employer with similar case characteristics (other than risk characteristics) as the employer under the applicable accident and health contract (determined on the 1st day of the rating period applicable to such contracts) exceeds such rate on the 1st day of the rating period applicable to the contract being renewed.

"(ii) CASES WHERE NO NEW BUSINESS.—If no new contracts are being issued for a class of business during any rating period, the applicable percentage shall be the percentage (if any) by which the lowest premium rate determined under paragraph (2)(B)(i) with respect to the renewal contract exceeds such rate for the contract to be renewed.

"(g) DISCLOSURE AND RECORDKEEPING, ETC. REQUIREMENTS.—The requirements of this subsection are met if—

"(1) DISCLOSURE.—Any person issuing an applicable accident and health insurance contract shall include in any sales materials the following:

"(A) The extent to which premium rates are based on risk characteristics and on factors other than risk characteristics.

"(B) The extent to which the person may change the premium rates.

"(C) The class of business within which the contract falls, including a description of the grouping of contracts within a class of business.

"(D) Provisions relating to renewability.

"(2) RECORDKEEPING, ETC.—Any person issuing an applicable accident and health insurance contract shall—

"(A) maintain at its principal place of business a complete and detailed description of its rating and renewal underwriting practices, and the information on which such practices are based, and

"(B) file with the Secretary each year an opinion of a qualified health actuary, based on a review of appropriate records, that the rating practices of such person for the preceding year are based upon commonly accepted actuarial assumptions and in accordance with the provisions of this section and sound actuarial principles.

For purposes of paragraph (2), the term 'qualified health actuary' means a member of the American Academy of Actuaries who is qualified by reason of prior and continuing education and relevant experience to render the actuarial opinion.

"(h) APPLICABLE ACCIDENT AND HEALTH INSURANCE CONTRACT.—For purposes of this section—

"(1) IN GENERAL.—The term 'applicable accident and health insurance contract' means a contract under which a person authorized under applicable State insurance law provides a health insurance plan or arrangement to an eligible small employer. Such term does not include any self-insured plan of an employer.

"(2) CERTAIN CONTRACTS NOT COVERED.—The term 'applicable accident and health insurance contract' does not include any contract—

"(A) which provides for accident only, dental only, or disability only coverage,

"(B) which provides coverage as a supplement to liability insurance,

"(C) which provides insurance arising out of a workmens' compensation or similar law, or automobile medical-payment insurance, or

"(D) which provides insurance which is required by law to be contained under any self-insured plan of an employer.

"(3) EXCEPTION FOR SMALL ISSUERS.—The term 'applicable accident and health insurance contract' shall not include any contract issued during a taxable year by a person which had less than $1,000,000 in gross premiums from accident and health contracts during the preceding taxable year. For purposes of the preceding sentence, the aggregation rules of section 448(c) shall apply.

"(i) OTHER DEFINITIONS.—For purposes of this section—

"(1) CLASS OF BUSINESS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'class of business' means, with respect to accident and health insurance provided to eligible small employers, all accident and health insurance provided to such employers.

"(B) ESTABLISHMENT OF GROUPINGS.—An insurer may establish separate classes of business with respect to accident and health insurance provided to eligible small employers but only if such classes are based on 1 or more of the following:

"(i) Business marketed and sold through persons not participating in the marketing and sale of such insurance to other eligible small employers.

"(ii) Business acquired from other insurers as a distinct grouping.

"(iii) Business provided through an association of not less than 20 eligible small employers which was established for purposes other than obtaining insurance.

"(iv) Business related to managed health care arrangements.

"(v) Business within groupings under clauses (i) through (iv) which is based on risk selection or underwriting criteria expected to produce substantial variations in claims costs.

"(vi) Any other business which the Secretary (a) determines needs to be separately grouped to prevent a substantial threat to the solvency of the insurer.

"(2) CHARACTERISTICS.—

"(A) IN GENERAL.—The term 'characteristics' means, with respect to any insurance rating system, the factors used in determining rates.

"(B) RISK CHARACTERISTICS.—The term 'risk characteristics' means factors related to the health risks of individuals, including health status, prior claims experience, the duration since the date of issue of a health insurance plan or arrangement, industry, and occupation.

"(C) GEOGRAPHIC FACTORS.—In applying geographic location as a characteristic, an insurer may not use for purposes of this section areas smaller than Census Bureau designations of metropolitan statistical areas and nonmetropolitan statistical areas.

"(3) ELIGIBLE EMPLOYEE.—The term 'eligible employee' means any employee other than an employee who works less than 30 hours per week. For purposes of this paragraph, the term 'employee' includes a self-employed individual as defined in section 401(c)(1).

"(4) ELIGIBLE SMALL EMPLOYER.—The term 'eligible small employer' means an employer who normally employed 50 or fewer employees on a normal business day. (For purposes of the preceding sentence, all employees covered under the same health insurance plan or arrangement covered by a contract shall be treated as 1 employer).

"(b) CONFORMING AMENDMENT.—The table of sections for chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new item:

"Sec. 4980C. Failure to satisfy coverage and rating standards of health insurance of small employers."

"(C) EFFECTIVE DATE.—

"(1) IN GENERAL.—The amendments made by this section shall apply to contracts issued, or renewed, after the date of the enactment of this Act.

"(2) TRANSITION RULE.—In the case of any contract in effect on the date of the enactment of this Act, the provisions of section 4980C(f)(1)(A) shall not apply to the first renewal of such contract.

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By Mr. BURNS:

S. 3261. A bill to amend title 23, United States Code, to assist in the development of travel and tourism as a multi-purpose land use of public lands for travel and tourism purposes, and for other purposes; to the Committee on Environment and Public Works.

FEDERAL RURAL TOURISM AND RECREATIONAL DEVELOPMENT INITIATIVE ACT

Mr. BURNS. Mr. President, this session the Senate passed several bills that contained rural economic development initiatives based on amenity resources. These resources can include historical attributes, cultural events, outdoor recreational opportunities, wildlife, scenery, and other natural or manmade resources and activities.

The bill I am introducing today complements those initiatives. It will also complement S. 1791, the Rural Tourism Export Promotion Act, a bill sponsored by Senator ROCKEFELLER and I which passed the Senate earlier this year. S. 1791 amends the International Travel Act of 1981 and creates a nonprofit Rural Tourism Foundation to develop and implement a plan to increase international awareness of Federal scenic and recreational lands through cooperative programs with the private sector.

In 1989, Federal agencies recorded 1.8 billion visits to recreational sites, parks, parkways, and historic sites. Be-

## Prepared Statement of Mark Gorman

Mr. Chairman and members of the Committee, my name is Mark Gorman. I am senior director of government affairs for the National Restaurant Association, the leading trade group for the nation's 710,000-unit foodservice industry.

I testify today on behalf of the Healthcare Equity Action League, also known as HEAL. Last October, the National Restaurant Association joined several other business associations in founding HEAL. Since then, over 360 major firms and organizations have signed up as members of HEAL. These groups now represent more than one million employers and 35 million employees. HEAL is diverse. Our roster, which continues to grow, includes small businesses, corporations, associations, health care providers, and insurers. I have attached a list of HEAL's members for the committee's information.

Our message is simple, and it is immediate: We need help in bringing down health insurance costs, and we need it TODAY. The ONLY way we can solve the access problem is by solving the cost problem.

Despite our diversity, members of HEAL have agreed on seven fundamental principles for reform. These are practical — not radical — changes. In fact, these are the same principles we see time and time again, underpinning numerous lists of suggestions for ways to ease the immediate crisis.

Mr. Chairman, HEAL commends you for introducing legislation that in many provisions echoes these same principles. We support your efforts to lead Congress in enacting them today and giving them a chance to work, and pledge to do whatever we can to help you.

In the arena of health-care reform, where consensus is fragile, these principles have gathered support from Democrats and Republicans alike. Why? Because everyone involved in the debate recognizes that these changes would mean health insurance coverage for millions of uninsured Americans. They are market-oriented changes that would improve and expand the current system rather than tearing it down and replacing it with something untested, unproven, or that would have dire consequences for employers or for the quality of U.S. health care.

Let me outline HEAL's seven principles in relation to your bill.

- First, HEAL endorses the full preemption of state health insurance mandates. Your bill, Mr. Chairman, takes the important first step of preempting state mandates for small employers as long as they provide a basic or standard health care plan. Under S. 1872, states could not prohibit the offering of the standard benefit package to small groups in the state.

  Small businesses that can't afford to self-insure face nearly 1,000 state mandates that require them to cover treatments ranging from acupuncture to chiropractors. While well-intentioned, these laws price many health-insurance policies out of the reach of the small businesses who want to offer basic coverage to their employees.

  HEAL encourages you to take your bill a step further, Mr. Chairman, and provide relief from state mandates to all purchasers of health insurance — large and small. It is only by taking such measures to reduce costs that access to health care can be broadened.

- Second, HEAL would like to see the elimination of state laws that restrict managed care. We applaud S. 1872 for recognizing that managed-care plans are key to slowing the growth of health care costs.

Members of HEAL continually run up against the same legal barriers when trying to buy affordable health care: the slew of frustrating state laws that restrict managed-care programs. These programs are providing many cost-cutting innovations in health-care delivery. But state laws that limit our ability to make selective contracts with physicians, for example, or make it difficult for us to give individuals any incentive to be cost-conscious when making health-care decisions, simply tie our hands. Eliminating these barriers would empower us — as insurance purchasers — to help bring down costs.

- Third, HEAL is in favor of reforming the insurance market for small businesses. Small businesses today face an insurance market that is unpredictable, arbitrary, and unaccountable to its customers.

  In the foodservice industry that I represent, we hear story after story of insurance companies that cancel or refuse to renew policies after expensive claims are filed; of businesses that experience double or triple digit annual premium increases that far outpace national averages; and of the thousands of workers with pre-existing health conditions who often cannot find coverage at any price.

  The current system gives insurers incentive to compete — but only to underwrite plans for healthy individuals. As employers who are interested in providing coverage for <u>all</u> our employees, the current system leaves us literally helpless in our quest to find affordable coverage.

  S. 1872 appears to be fully consistent with HEAL's principles in the area of small-market reform. We ask you to move ahead with these.

- Fourth, S. 1872 would immediately raise the tax deduction for owners of unincorporated businesses to 100%. This segment of the business community — the self-employed, sole proprietorships, S-Corporation owners, and partnerships — experiences some of the highest premiums in the country. HEAL wholeheartedly backs S. 1872's provisions that would expand health care coverage among these business owners by equalizing tax treatment.

- Fifth, HEAL endorses getting better information to consumers about how to purchase health care, and about which treatments are the most effective.

  A market economy works only when consumers have access to reliable information about prices and products. This is missing from today's health care situation. S. 1872 would authorize money for additional "outcomes research," which we believe is an important component of restoring these market forces to health care purchasing.

- Sixth, HEAL supports measures to reduce the growth of health care costs. However, we support cost containment rather than strict cost controls. S. 1872 proposes establishing a commission to study these issues: HEAL recommends giving this commission tight parameters for its mission to ensure objective validity, as well setting a strict deadline for reporting back to Congress with its findings.

- Finally, S. 1872 makes no attempts to reform medical malpractice laws. HEAL encourages you to add these provisions to your bill. Giving health care providers some degree of protection from the costs of exorbitant litigation will remove one of the major reasons health care professionals practice defensive medicine and prescribe unnecessary care. These factors have dramatically driven up the cost of insurance.

HEAL believes these seven steps will lessen the current problem, which has indeed reached crisis levels. This crisis demands immediate attention — but this immediacy won't happen without some sort of consensus. This is what we believe HEAL's seven principles provide. HEAL's broad membership base proves that support for these seven principles is deep and wide. And HEAL's members have made a serious commitment to work with you and others, Mr. Chairman, to get these reforms enacted into law.

APPENDIX A

## *HEALTHCARE EQUITY ACTION LEAGUE (HEAL)*

### *GENERAL MEMBERSHIP*

Advertising Specialty Institute
Acrospace Industries Association
Air-conditioning & Refrigeration Wholesalers Association
Alabama Wholesale Beer & Wine Association
Albertson's, Inc.
Allen Park (MI) Chamber of Commerce
Alliance of American Insurers
The Aluminum Association
American Council on Education
American Electronics Association
American Federation of Small Business
American Machine Tool Distributors Association
American Meat Institute
American Paper Institute
American Society of Computer Dealers
American Supply Association
American Traffic Safety Services Association
American Veterinary Distributors Association
American Wholesale Hardware Association
Appliance Parts Distributors Association
Ardmore (OK) Chamber of Commerce
Arizona Restaurant Association
Arnett & Company Health Communications
Associated Beer Distributors of Illinois
Associated General Contractors
Association of Commerce and Industry (MI)
Association of Ingersoll-Rand Distributors
Association of Steel Distributors
ATLAND Management Corporation
Atlanta (GA) Chamber of Commerce
Automotive Service Industry Association
Aviation Distributors & Manufacturers Association
Baker Industries, Inc.
Baptist Medical Center of Oklahoma
Beauty & Barber Supply Institute
Becton Dickinson & Company
Beer & Wine Association of Ohio
Beer Industry League of Louisiana
Beer Industry of Florida
Beer Wholesalers Association of New Jersey
Benefit Design Group, Inc.
Benihana National Corporation
Berghoff Restaurant Company
Bicycle Wholesale Distributors Association
Biscuit & Cracker Distributors Association
Bismarck-Mandan Area (ND) Chamber of Commerce
Bob Chinn's Crabhouse Restaurant
Boon-Chapman
California Association of Tobacco & Candy Distributors
California Association of Wholesalers-Distributors
California Beer & Wine Wholesalers Association
California Trucking Association
Carroll County (MD) Chamber of Commerce
Central Wholesalers Association
Ceramic Tile Distributors Association
Chamber of Commerce of Hawaii
Chamber of Commerce of New Rochelle (NY)
Charles M. Ostheimer & Associates, Inc.
Chicago Metropolitan Distributors Association
Chicago Tastee Freez Corporation
Chocolate Manufacturers Association
Christian Booksellers Association
Clemson Area (SC) Chamber of Commerce
Colorado Beer Distributors Association
Colorado Restaurant Association
Computer Dealers & Lessors Association
Copper & Brass Servicenter Association
Council for Periodical Distributors Association
The County (NY) Chamber of Commerce, Inc.
Crawford Fitting Company
Dairy and Food Industries Supply Association
Davenport (IA) Chamber of Commerce
Digital Dealers Association
Direct Selling Association
Eagle Creek Resort, Inc.
Eckerd Drug Company
Electrical-Electronics Material Distributors Association
Employee Managed Care Corporation
Engine Service Association
Express Visa Service, Inc.
Farm Equipment Wholesalers Association
Fire Suppression Systems Association
Fluid Power Distributors Association
Folk's Folly Prime Steak House
Food Industries Suppliers Association
Food Processing Machinery and Supplies Association
Foodmaker, Inc.
Foodservice Equipment Distributors Association
Gail F. Piltz Inc/DBA Comprehensive Accounting
General Merchandise Distributors Council
Georgia Beer Wholesalers Association
Glenwood Springs (CO) Chamber Resort Association
Goldendale (WA) Chamber of Commerce
Grand Rapids Area (MI) Chamber of Commerce
Greater Detroit Chamber of Commerce Wholesaler-Distributor Association
Greater Iberia (LA) Chamber of Commerce
Greater Martinsville (IN) Chamber of Commerce
Greater North Dakota Association/WAM Council
Greater Ohare (IL) Association
Greater Raleigh (NC) Chamber of Commerce
Greater Washington Food Wholesalers
Gwinnett (GA) Chamber of Commerce
Hardee's Food Systems, Inc.
HealthTrust, Inc.
Henderson (NV) Chamber of Commerce
Hobby Industry Association of America
Hoffmann-La Roche Inc.

Home Health Care
Hospital Corporation of America
Hospitality Association of South Carolina
Illinois Restaurant Association
Independent Electrical Contractors, Inc.
Independent Laboratory Distributors Association
Independent Medical Distributors Association
Independent X-ray Dealers Association
Indiana Beverage Alliance
Indiana Restaurant Association
Institutional & Service Textile Distributors Association
Insurance Administration Center, Inc.
International Association of Amusement Parks and Attractions
International Dairy Foods Association
International Truck Parts Association
International Sanitary Supply Association
Iowa Grain and Feed Association
Iowa Restaurant & Beverage Association
Irrigation Association
JT&A, Inc.
Jewelry Industry Distributors Association
Jobbers Credit Association
John M. Regan & Associates, Inc.
Johnson & Johnson
Kansas Chamber of Commerce & Industry
Ki-Star Group of Texas, Inc.
The Krystal Company
Lenert Plumbing, Inc.
Lenoir County (NC) Health Cost Containment Coalition
Lettuce Entertain You
The Levy Restaurants
Long John Silver's, Inc.
Los Angeles Fasteners Association
Louisiana Restaurant Association
Machinery Dealers National Association
Malcolm Thompson, Magaro & Associates
Manitowoc-Two Rivers (WI) Chamber of Commerce
Massachusetts Restaurant Association
Material Handling Equipment Distributors Association
MDU Resources Group, Inc.
Meeker Sharkey Benefits
Metro East (MI) Chamber of Commerce
Michigan Association of Distributors
Michigan Beer & Wine Wholesalers Association
Michigan Distributors & Vendors
Mid-America Supply Association
Middle Atlantic Wholesalers Association
Mississippi Malt Beverage Association
Missouri Beer Wholesalers Association
Missouri Restaurant Association
Montgomery County Pharmaceutical Association of Pennsylvania
Morning Glory Dairy
Morton's of Chicago, Inc.
Motorcycle Industry Council
Mount Vernon (NY) Chamber of Commerce
Music Distributors Association
National Appliance Parts Suppliers Association
National Appliance Service Association
National Association of Chemical Distributors
National Association of Container Distributors
National Association of Electrical Distributors
National Association of Fire Equipment Distributors
National Association of Floor Covering Distributors
National Association of Flour Distributors
National Association of Hose and Accessories Distributors
National Association of Meat Purveyors
National Association of Realtors
National Association of Recording Merchandisers
National Association of Service Merchandising
National Association of Sign Supply Distributors
National Association of Sporting Goods Wholesalers
National Association of Wholesale Independent Distributors
National Beer Wholesalers Association
National Building Material Distributors Association
National Business Forms Association
National Business Owners Association
National Candy Wholesalers Association
National Club Association
National Commercial Refrigeration Sales Association
National Electronic Distributors Association
National Fastener Distributors Association
National Food Distributors Association
National Frozen Food Association
National Grocers Association
National Independent Poultry & Food Distributors Association
National Industrial Glove Distributors Association
National Insulation and Abatement Contractors Association
National Lawn & Garden Distributors Association
National Locksmith Suppliers Association
National Marine Distributors Association
National Office Products Association
National Paint Distributors
National Paper Trade Association
National Sash & Door Jobbers Association
National School Supply & Equipment Association
National Solid Wastes Management Association
National Spa & Pool Institute
National Truck Equipment Association
National Welding Supply Association
National Wheel & Rim Association
National Wholesale Furniture Association
National Wholesale Hardware Association
New England Paper Merchandising Association
New England Wholesalers Association
New York State Beer Wholesalers Association
New York State Plumbing & Heating Wholesalers
New York State Restaurant Association
North American Horticultural Supply Association
North American Wholesale Lumber Association
Northamerican Heating & Airconditioning Wholesalers Association
North Carolina Beer Wholesalers Association
North Carolina Wholesalers Association
Northern Berkshire (MA) Chamber of Commerce
Northern Rhode Island Chamber of Commerce

Northwestern Public Service Company
Oklahoma State Chamber of Commerce & Industry
Optical Laboratories Association
Orange County (NY) Chamber of Commerce
Oregon Restaurant and Hospitality Association
Outdoor Power Equipment Distributors Association
Pacific Southwest Distributors Association
Pasadena (CA) Chamber of Commerce
Pennsylvania Chamber of Business and Industry
Pennsylvania Restaurant Association
Pet Industry Distributors Association
Petroleum Equipment Institute
Petroleum Marketers Association of America
Piscataway-Middlesex Area (NJ) Chamber of Commerce
Pocono Mountains Chamber of Commerce
Potlatch Corporation
Power Transmission Distributors Association
Produce Marketing Association
Pueblo (CO) Chamber of Commerce
Reno Sparks Convention and Visitors Authority
Restaurant Association of Maryland
Rhode Island Hospitality Association
Riverdale (NJ) Texaco
Safety Equipment Distributors Association
Santa Ana (CA) Chamber of Commerce
Schiffli Lace & Embroidery Manufacturers Association
Schererville (IN) Chamber of Commerce
Scripps Memorial Hospitals
Selfridge & Associates, Inc.
Shoe Service Institute of America
Small Business of America
Snack Food Association
Society of Professional Benefits Administrators
South Carolina Beer Association
Southern Wholesalers Association
Southworth-Milton, Inc.
Specialty Tools & Fasteners Distributors Association
Spraying Systems Company
St. Lucie County (FL) Chamber of Commerce
Star Administration Services, Inc.
Steel Service Center Institute
Storm Lake (IA) Chamber of Commerce
Suspension Specialists Association
Swartz Restaurants Corporation
Tennessee Malt Beverage Association
Tennessee Restaurant Association
Texas Restaurant Association
Textile Care Allied Trades Association
Thomas Jefferson University Hospital
Thornton Gardens Inc.
Twinsburg (OH) Chamber of Commerce
Unimax Hearing Instruments, Inc.
United Products Formulators & Distributors Association
United Restaurant & Lodging Association
Virginia Restaurant Association
Walker Health Insurance Services, Inc.
Wallcovering Distributors Association
Warren County (PA) Chamber of Commerce
Washington (IL) Chamber of Commerce
Waste Management Inc.
Water & Sewer Distributors of America
Wausau Hospital Center
Western Association of Fastener Distributors
Western Suppliers Association
Wholesale Beer Distributors of Arkansas
Wholesale Beer Distributors of Texas
Wholesale Distributors Association
Wholesale Florists & Florist Suppliers of America
Wholesale Stationers' Association
Wine & Spirits Wholesalers of America
Wisconsin Wholesale Beer Distributors Association
Woodworking Machinery Distributors Association
Woodworking Machinery Importers Association
Wyoming Lodging & Restaurant Association

# *Healthcare Equity Action League (HEAL)*

## *STEERING COMMITTEE*

Aetna Life & Casualty
American Apparel Manufacturers Association
American Association of Preferred Provider Organizations
American Bakers Association
American Cyanamid Company
American Farm Bureau
American Furniture Manufacturers Association
American Hardware Manufacturers Association
American Hotel & Motel Association
American Institute of Architects
American International Hospital
American Managed Care & Review Association
American Trucking Association, Inc.
AMGEN Inc.
Amway Corporation
Associated Builders and Contractors
Associated Equipment Distributors
Associated Landscape Contractors of America
Association for Suppliers of Printing and Publishing Technologies
Association of Health Insurance Agents
The Beer Institute
Beneficial Management Corporation
Burroughs Wellcome Company
Cancer Treatment Centers of America
Carl Karcher Enterprises
Caterair International Corporation
Central Reserve Life Insurance Company
The CIGNA Corporation
Citizens for a Sound Economy
Council of Smaller Enterprises
Eli Lilly & Company
Employee Benefits South, Inc.
Evanston Hospital Corporation
Federation of American Health Systems
Florists' Transworld Delivery Association
Food Marketing Institute
The Grand Union Company
Group Health Association of America
Hampshire House
Harman Management Corporation
Harris Methodist Health System
Health Industry Distributors Association
Health Industry Manufacturers Association
Health Insurance Association of America
Health Midwest
Health One
Healthcare Leadership Council
Hershey Foods Corporation
Hillcrest Baptist Medical Center
Holiday Inn Worldwide
Humana Inc.
Industrial Distribution Association
International Mass Retail Association
John Hancock Mutual Life Insurance Company
Kimberly Quality Care
The Law Offices of Deborah Steelman
Marriott Corporation
Massachusetts Mutual Life Insurance Company
McDonald's Corporation
Melrose Diner, Inc.
Metropolitan Life Insurance Company
Mobile Technology Inc.
Morrison Incorporated
Motorola Inc.
Mutual of Omaha
National-American Wholesale Grocers' Association
National Association of Aluminum Distributors
National Association of Chain Drug Stores
National Association of Convenience Stores
National Association of Health Underwriters
National Association of Temporary Services
National Association of Wholesaler-Distributors
National Committee for Quality Health Care
National Council of Chain Restaurants
National Council of Community Hospitals
National Federation of Independent Business
National Medical Enterprises, Inc.
National Restaurant Association
National Retail Federation
National Wholesale Druggists' Association
New York Life Insurance Company
NMTBA-The Association for Manufacturing Technology
Pagonis & Donnelly Group, Inc.
Pennsylvania Hospital
PepsiCo
The Principal Financial Group
Printing Industries of America
The Prudential
Schering-Plough Corporation
Sears, Roebuck and Co.
ServiceMaster Management Services
Society of American Florists
St. Joseph Healthcare Group, Inc.
Super Valu Stores, Inc.
The Travelers Companies
U.S. Chamber of Commerce
U.S. Federation of Small Businesses, Inc.
Wendy's International, Inc.
Western Growers Assurance Trust
Wills Eye Hospital

## *HEALTHCARE EQUITY ACTION LEAGUE (HEAL)*

### *STEERING COMMITTEE*

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The Travelers Companies
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APPENDIX B

# HEALTHCARE EQUITY ACTION LEAGUE

## *SOLVING THE HEALTH CARE CRISIS: STATEMENT OF BASIC PRINCIPLES*

We support an effective, affordable, free enterprise solution to the health care cost crisis facing the Nation.

Problems of cost and financing have limited access to quality health care for the millions of Americans who do not now have health care coverage; and they jeopardize future access for the additional millions of Americans whose insurance coverage is at risk due to rising costs or expensive personal health problems.

We strongly believe that viable solutions to the health care crisis must address the problems of cost and access in tandem. We also believe that solutions must be immediate, substantive, incremental, and based on market principles, relying on a mixture of incentives and structural and legislative reforms.

Problems of access will not be solved through any form of national health insurance or through federally-mandated coverage. We oppose so-called "play or pay" proposals which would require all employers to provide health insurance to their employees or pay an excise tax. Trigger proposals which would mandate health insurance by a time certain if it were not otherwise generally made available by employers are unacceptable as well.

We oppose proposals to restructure our health care system with government imposed controls. We also oppose proposals that would have government tell patients how much health care they can have, rather than realistically addressing the causes of the cost spiral.

We fully recognize that the health care crisis cannot be solved by maintaining the status quo. More to the point, the problems will only get worse if delay of relief occurs on issues of general consensus for the sake of extended public debate on highly controversial proposals.

In fact, our respective memberships demand change and relief. Therefore, while we firmly oppose certain universal proposals, we recommend that the following specific, positive steps be implemented as expeditiously as possible:

- ***Full Federal Preemption of State Health Insurance Mandates.*** There are currently over 800 state mandates which impose a myriad of requirements on health insurance policies, thus significantly increasing the cost of premiums for non-self-insured businesses and the cost of health care for all businesses. Freeing all policies from these well-meaning but counterproductive mandates would immediately and significantly lower the cost of health insurance for all firms and increase access for small business and individuals alike.

- ***Preemption of State Laws Which Restrict Managed Care and Cost Sharing.*** Managed care systems have proven effective. Yet, a number of states have enacted so-called "freedom-of-choice" laws or other provisions that block the efforts of those who buy health care to implement innovative managed care systems. Further, many states have regulations limiting the amount of cost-sharing by individuals, thereby inhibiting selective contracting arrangements and barring incentives needed to encourage employees to be cost conscious in their decision-making. Eliminating barriers to managed care could substantially reduce costs due to wasteful or inappropriate care.

- ***Reform of Insurance Underwriting.*** To assure health care access, health insurers, HMO's and other plan sponsors should guarantee the availability and renewability of health insurance to those who wish to purchase it, regardless of size, status, or geographical location of the purchaser. Risk-sharing should be increased by elimination of rating practices which penalize individuals and small employers. Further, the denial of health insurance to employees and dependents due to pre-existing conditions when an employer changes his insurer or when employees change jobs should be prohibited. Cancellation of insurance when employees or dependents file claims should also be prohibited.

- ***Reform of Medical Malpractice Provisions.*** Prudent malpractice reform will reduce the need for costly defensive testing and other forms of health care delivery used to avert malpractice claims.

- ***Full Deductibility of Health Insurance Premiums for All Businesses.*** While incorporated businesses are allowed to deduct 100 percent of their health insurance premiums, partnerships, sole proprietors and S-corporations only receive a 25 percent deduction. The tax code should be amended to provide equal treatment to all businesses, which would in turn provide an incentive to smaller companies to obtain or expand health insurance.

- ***Consumer Empowerment and Individual Responsibility.*** A competitive health care marketplace will not occur unless patients behave like educated consumers who believe that they have a responsibility to make good health care decisions. Patients must become active and informed participants in their own care and their own well-being. In order that they and their surrogates may have timely and reliable information on fees, treatments, and physician practices, the development and dissemination of data, including outcomes research, and appropriate practice protocols and hospital ratings should be encouraged. Wellness education is another significant key to controlling future health care expenditures.

- ***Health Care Cost Increases Must be Brought Under Control.*** While the recommendations listed above will have salutary effects on escalating costs and on current cost-shifting to the employer-based system, more will need to be done. The development of a market based system can provide affordable health care without compromising quality. Incentives must be provided for government, providers, and private insurers to aggressively pursue innovative purchasing and managed care techniques. Health care providers must become part of the solution to escalating health care costs.

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Thank you, Mr. Chairman.

Mr. Chairman, I want to thank you for the leadership you have shown in introducing this legislation.

I think that we have developed a consensus that reform of the small group health insurance market, such as that contemplated by your legislation, is needed, is important, and is possible this year. I think most interested parties believe that passage of small group health insurance reform would be a major step forward.

If there are any differences among interested parties, they do not seem to be on the basic question of whether we ought to be trying to reform this market. Instead, they are over questions of detail.

I don't mean to minimize such differences. They can be important.

One of the things I am concerned about, for instance, is the appropriate rating bands for what the insurers call blocks of business. It seems clear that, as we impose limits on the variation in premium prices that insurers can charge small groups for health insurance policies, some of those groups will experience increases in premiums.

If some of the insurers are to be believed, some of those increases could be substantial.

Now, maybe that's a small price to pay for achieving greater reasonableness in the cost of health insurance for many other small groups.

On the other hand, some small groups may have to drop insurance coverage if the premium increases are too great. If this happens, we could just be compounding the access problem we are trying to reduce.

I will be interested to hear what our witnesses have to say on this question.

I am also concerned about the degree of flexibility which should be provided the various States in this legislation. I was struck by the point, made by one of our witnesses in his written testimony, to the effect that State marketplaces differ dramatically. He asserted that the same reform in one State may cause very little disruption, but in others may be very disruptive.

My own State of Iowa is one of the small number of States that has recently implemented reforms along the lines of the model law proposed by the national association of insurance commissioners. I would like to have some assurance that the bill we are considering today would not disrupt what we have managed to accomplish in Iowa.

I will have some questions for our witnesses along these lines, Mr. Chairman, and I am looking forward to the testimony.

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PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

Thank you, Mr. Chairman, I'll be brief.

Today's hearing centers on S. 1872, the bill that you introduced to reform the health insurance marketplace, control rising health care costs, and expand Medicare benefits to cover certain prevention activities.

Before we hear from the witnesses today, I think it is appropriate to step back for a moment and reflect upon the importance of health care reform, and how we get there from here.

At Tuesday's hearing several members, including the Majority Leader, spoke eloquently about the growing public outcry for repairing the health care system. Secretary Sullivan told us that the President has made reform a top national priority by developing his plan.

As we continue through the legislative process, we must remember that ultimately what is at stake here is the security of our Nation's most precious commodity—the family.

To the extent possible in this election year, we should try to focus our efforts on taking steps that represent the best policy and not politically expedient measures that sound good now but become unaffordable or otherwise unattractive *later*.

As we proceed down the path of reform, we must be respectful of our genuine differences of opinion on these complex questions and *seek* out and *arrive* at common ground. This will not be easy, and it will be particularly difficult with our form of democracy.

On this Committee alone we hold widely divergent views on basic issues such as the proper role of the Federal and State governments in health care, the extent to which the private health care market should be retained and regulated, and precisely what type of individual rights and responsibilities should be reflected in our health care system.

We should respect each others' views and values and—for the good of the American people—do our best to reach an acceptable solution that takes these values into consideration.

In this spirit, Mr. Chairman, there is *much* to say in favor of *much* of your bill, particularly in the area of small market reform. There is great similarity between S. 1872 and many other health reform proposals. The President's proposal also encourages small market reform. Although not 100 percent identical in detail and broader in scope, the plan of the Senate Republican Health Care Task Force is consistent in spirit with S. 1872, as far as your bill goes, Mr. Chairman.

A major concern that I have with your bill—after we iron out all the nitty-gritty details—is whether it goes far enough. Don't get me wrong, Mr. Chairman, I commend you for putting this piece of legislation on the table. I recognize that, given the difficulties of election year politics, even this piece of legislation may prove too much.

Let me just say, Mr. Chairman, that I support the intent of your legislation and I am committed to working closely with you, and other members of the Committee, to fashion our best efforts into a truly a bipartisan solution to this seemingly intractable problem.

*Not* to support these types of reform would be a mistake *but* to support *only* these reforms would also be a mistake.

To fix the health care system more completely, other corrective measures will be needed. These range from community health' centers and reforming the medical liability system to the question of how to ensure that the proper incentives are included in our health care financing system.

We've got to start this job somewhere, and I want to go on record as stating that S. 1872 is a much more promising avenue than the "Health-America" bill. I am afraid that the Health America Bill would not only worsen our already threatened economy but also tear at the fabric of our society by pitting small business against large; young against old; and well against sick.

Mr. Chairman, I commend you for your efforts to address the serious problems in our health care system, and I look forward to working with you in this effort and to hearing from our witnesses today.

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PREPARED STATEMENT OF KAY JOHNSON

Chairman Bentsen and Members of the Committee, on behalf of the March of Dimes Birth Defects Foundation, I would like to thank you for the opportunity to appear before you today. I also would like to commend you for your continued interest in the pressing problem of health care financing. The March of Dimes shares the concern of other voluntary health organizations, health professionals, business, labor, and elected leaders about the growing number of uninsured Americans, and the high (and growing) cost of health care. The mission of the March of Dimes is to improve the health of babies by preventing birth defects and infant mortality. Thus, we have a special interest in the barriers to access to care faced by millions of American families who want to have healthy babies.

I have submitted written remarks. In the interest of time, I will briefly summarize my written testimony.

I. WHAT PROBLEMS RESULT FROM OUR NATION'S FAILURE TO ENSURE UNIVERSAL ACCESS TO HEALTH CARE?

The Nation simply cannot afford to continue on its present course. This is especially true if we are to make good on our moral and ethical responsibilities to ensuring that babies are born with the greatest chance of survival.

- Each year, nearly 40,000 infants die before their first birthday. More than 8,000 of these die as a result of a birth defect and thousands more die from low birthweight (less than 5.5 pounds).[1]
- The White House Infant Mortality Task Force estimated that every infant death represents $380,000 in lost productivity and that one-quarter of the total number of infant deaths could be prevented with the knowledge and technology now available.[2]

Many factors contribute to the Nation's excess infant mortality. However, inadequate access to health care during pregnancy and at the time of birth is a major contributor. Our policies and statistics reflect a half-hearted commitment to improving infant health and survival. Inadequate prenatal care is a key measure of access to health care for pregnant women and infants.

- We have made no progress in improving early prenatal care - use since 1979. A decade ago, one-quarter of all pregnant women received no prenatal care in the critical first three months of pregnancy. That figure has not changed.
- In 1989 more than 85,000 babies are born without benefit of any prenatal visits—this means that their mothers did not see a health provider before they arrived at the hospital to give birth.[3]

It is obvious that health status and utilization are linked to many factors. However, insurance is the first critical step in assuring access to services. In a landmark report on prenatal care, the Institute of Medicine reported that:

> "Financial barriers—particularly inadequate or no insurance and limited personal funds—were the most important obstacles reported in 15 studies of women who received insufficient care."[4]

From New York City to Oklahoma City, these studies document the financial barriers that keep women from receiving early and adequate prenatal care.

As the number of uninsured Americans has grown in recent years, women of childbearing age add children experienced a disproportionate impact. Workers' children and dependent spouses often are excluded from employer-based health insurance plans. Young families rarely can afford to buy the additional coverage which may cost $3,000 or more per year. As a result they live uninsured or underinsured. Consider these facts:

- In 1990, despite recent expansions of Medicaid, an estimated **443,000 pregnant women had no health insurance.**[5]
- In 1990 over 8.4 million women of childbearing age had no health insurance (Figure 1). Of these, 6 million were working women.[6]
- Nearly two-thirds of the uninsured are concentrated in low-income families. The majority live in two-parent, working families with children. The typical woman having a baby is from such a family—she is in her twenties, married, family income of just under $20,000 per year, with at least a high school education, and employed, or married to a man who is employed, full-time.[7] (Figure 2)
- Over 9.2 million working women do not participate in the health insurance plan offered by their employer. Of these, 36 percent are not eligible for benefits and 7 percent find the cost too high.[8] (Figure 3)
- Insurance coverage varies by occupation. Women workers employed in those sectors dominated by small businesses or where self-employment is common are most likely to have no health care coverage. (Figure 4)
- Women working in small businesses are much less likely than those employed in medium and large size firms to have health insurance. **In businesses with fewer than 25 employees, only 20 percent of women workers have employer-based health insurance,** as compared to more than 60 percent of those in large firms with 1000 or more employees.9 (Figure S)

The problems of being uninsured are most serious for low income families who cannot afford to pay for care "out-of-pocket." When a pregnancy occurs the need for care is urgent but may go unmet. The average bill for having a baby is estimated at over $4,000. (Figure 6) This conservative estimate, that assumes there are no complications, represents one-fifth of the average income of a couple in their early twenties.

Furthermore, the concept of insurance is eroding. Many of the sickest populations have been left behind. The preventive care needed by pregnant women and infants often is left out of private "basic benefit" packages.

- An estimated **5 million women of childbearing age have private insurance that does not cover maternity care.**[10] This means that prenatal care already is outside of the scope of coverage for thousands of pregnant women each year.
- Uninsured women often cannot afford to purchase "out-of-pocket" the basic services that might have given a baby a chance to survive, such as genetic screening or treatment for sexually transmitted diseases and infections.
- Infants born with a birth defect may have conditions that are excluded categorically from insurance plans. For those who survive, health care coverage may not be available to meet the cost of remedial care that could prevent or limit disabilities.

Lack of health insurance has a direct relationship to the use of health care services and to health status. Evidence indicates that even when uninsured pregnant

women and infants have obvious health needs and serious health problems, they receive significantly less care than their insured counterparts.

When we fail to assure access to care for pregnant women and children, we miss opportunities to prevent costly health problems. When families delay preventive care, society pays.

- Prenatal care has been found to be effective and cost effective—saving $3 for every $1 invested by improving infant health and reducing neonatal intensive care costs.
- Neonatal intensive care is among the most costly of all hospital services, and related hospital bills often go unpaid because infants are uninsured. About **one-quarter of unpaid hospital costs are for maternity and newborn care.**
- Immunizations, beginning in infancy and delivered on time can save $10 for every $1 invested. We pay more when infants do not receive vaccines and a case of preventable pertussis or measles is the result.

### II. WHAT ACTION MUST BE TAKEN IN RESPONSE TO THESE PROBLEMS?

It is clear that something must be done. The Nation cannot afford to spend 13 percent or more of GNP on health care. The debate on health care system reform is gaining momentum, and it will more clearly show the strengths and deficits of various approaches. However, action is urgently needed to help families and save babies from preventable deaths.

The March of Dimes believes strongly that the unique needs of pregnant women and infants must be considered in the health care reform debate. To that end, we have supported a project of the National Academy of Sciences, National Forum on the Future of Children and Families that will set out principles for evaluating the adequacy of health care reform proposals in relation to maternal and child health.[11]

In the broad health care reform debate, the March of Dimes believes that: (1) Any health care reform proposal should assure that all children and pregnant women have health care coverage, either public or private; (2) Insurance reform is a start, but it won't solve the crisis in access to health care—improvements are needed in the content, distribution, and appropriateness of services; (3) A health care reform plan should ensure comprehensive benefits for pregnant women and children, with emphasis on prevention; (4) Cost containment must be a priority, and strategies to better manage costs include the increased use of preventive services; and (5) A health care reform plan should not only focus on medical care, health research is critical to development of preventive interventions and improved outcomes.

In keeping with these principles, the March of Dimes supports the direction taken in S. 1872. We recognize that this legislation is not intended to be a substitute for the more "comprehensive", reform proposals introduced by other members of Congress and urge the Finance Committee to fully explore approaches for comprehensive reform. At the same time, more than 34 million Americans need health care coverage today. In an incremental approach such as that taken in S. 1872, we support the following:

- **Standard or basic benefit packages that emphasize prevention.** Specifically, benefit packages that include comprehensive maternity benefits (i.e. prenatal, labor and delivery, and postpartum services) and comprehensive well child care beginning in infancy (i.e. immunization services, preventive medical and dental screening tests and examinations). These benefits should be specifically referenced in legislative language describing benefits.
- **Mechanisms to ensure the quality of managed care plans.** Certification of plans and other quality assurance mechanisms are essential to protecting consumers and budgets. Care coordination has been shown to be effective in improving pregnancy outcomes in at least one State. However, reports from around the country indicate that managed care does not necessarily save money and that, left unsupervised, some managed care plans have failed to provide basic and preventive care to mothers and infants.
- **Efforts to eliminate pre-existing condition exclusions.** Pregnant women should not be subject to job lock for fear that they will be unable to transfer maternity coverage. Infants born with birth defects and other special health care needs should be covered from birth and not be excluded from coverage for necessary remedial care. The insurance industry should not be permitted to skim the top for the cream of our Nation's crop of children.
- **Funding for prevention and outcomes research.** Health services research to identify possible new treatments, determine the effectiveness of preventive interventions, and develop guidelines for coverage of preventive services is essential to cost management. Major gaps in evidence to evaluate the effec-

tiveness of preventive services have been documented.[12] The size of the research agenda in preventive medicine should be increased.

• **Reforms to increase health care coverage among workers in small businesses.** Employment in a small business usually translates into inadequate insurance coverage for families and children, particularly for pregnant women and infants. Efforts to make insurance affordable for small business owners are essential. We urge the committee to avoid any rating approach that would isolate or penalize pregnant women. Protecting the health of pregnant women and infants is a societal responsibility.

Mr. Chairman, we are not naive enough to believe that there are easy answers to the current crisis in health care. Your work, along with that of your colleagues, will shape and refine reforms in the Nation's health care system. We urge you to act thoughtfully and expeditiously to ensure access to care for all Americans. As you move forward, we hope that you will put pregnant women and children into the lifeboat first. Their health and productivity are the hope for tomorrow. We cannot afford to neglect their needs and our future.

ENDNOTES

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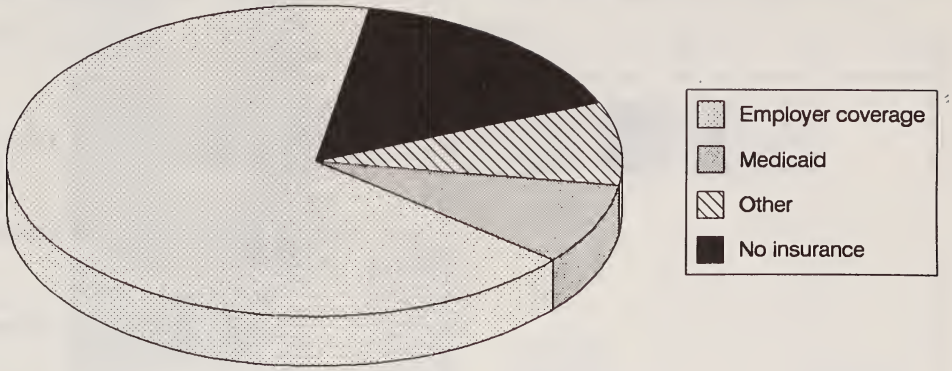
Figure 1

## Health Insurance Status of Women of Childbearing Age, 1990

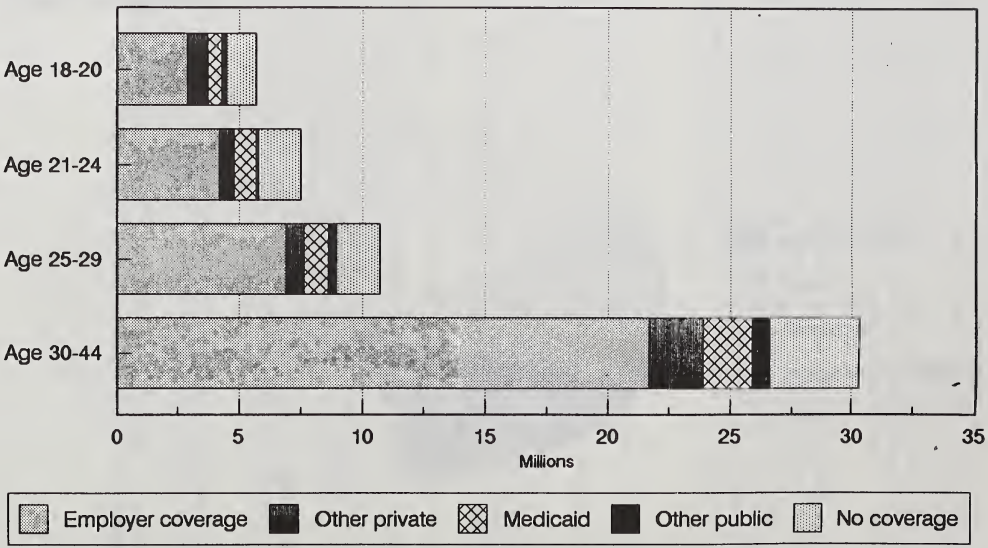



Source: Current Population Survey analysed by Employee Benefit Research Institute

March of Dimes, 1992

Figure 2

## Health Insurance Status Among Women of Childbearing Age, US, 1990

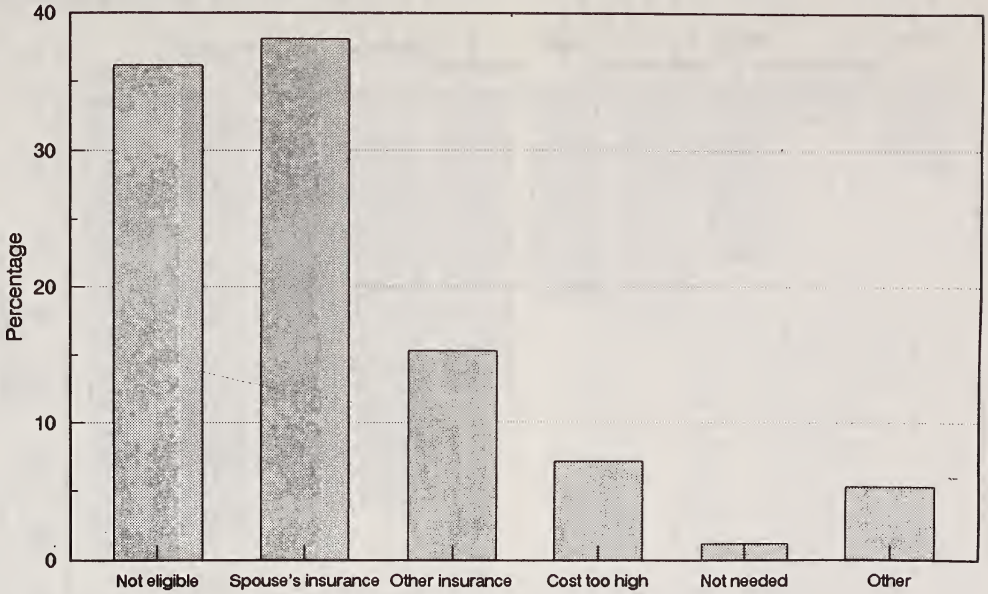



Source: Current Population Survey
Employee Benefit Research Institute

March of Dimes, 1992

Figure 3

## Reasons Working Women Did Not Participate In Employer Sponsored Health Insurance Plans, 1990

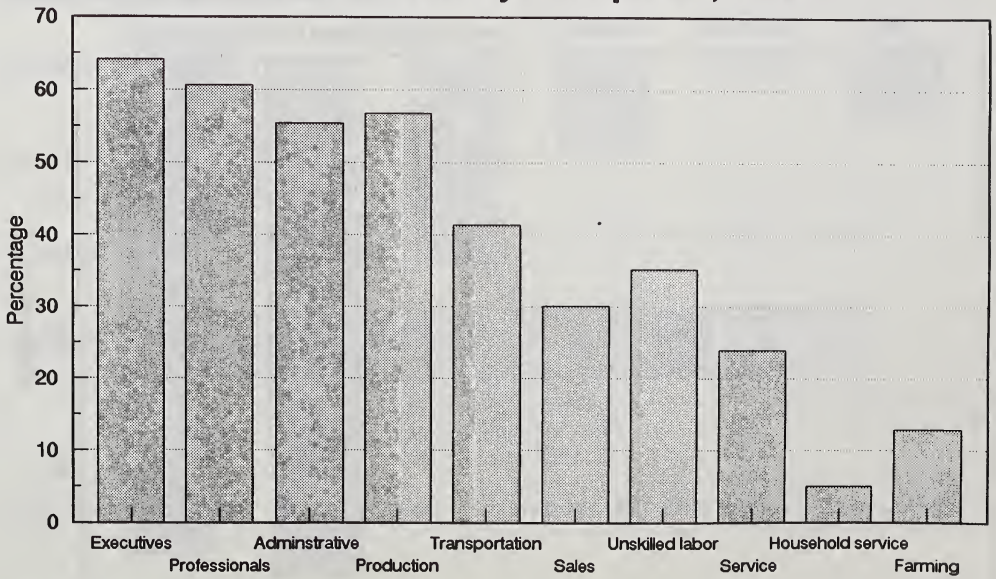



Source: Current Population Survey analysed by Employee Benefits Research Institute.

March of Dimes, 1992

Figure 4

## Percentage of Women with Employer-based Health Insurance By Occupation, 1990




Source: Current Population Survey analysed by Laurie Miller, "Uninsured and Underinsured Women, Employment and Employers," 1991.

March of Dimes, 1992

PREPARED STATEMENT OF ROBERT LEMOND

Mr. Chairman, my name is Robert LeMond. I am an architect from Fort Worth, Texas, and I am here today to represent the American Institute of Architects. I am a former president of the Texas society of Architects, a former member of the AIA's national Board of Directors, a former chairman of the AIA's national Government Affairs Committee, and am currently the chairman of the Texas Society of Architects Insurance Trust. I am also a member of the AIA's College of Fellows.

On behalf of the 56,000 members of the AIA, I would like to express our appreciation for this opportunity to testily on health care cost and access, and to commend your leadership in introducing S. 1872, the Better Access to Affordable Health Care Act. This legislation embraces the incremental approach to health care reform advocated by the AIA and avoids proposals that would restructure our health system to the detriment of quality, technology, and research.

Founded in 1857, the AIA is the Nation's professional association for architects. The Institute represents nearly 65 percent of the U.S. architectural profession. Most architects are either small business owners or employees, and therein lies our interest in your legislation.

The AIA endorses the general concepts of the entire bill, but there are three major provisions that we would like to examine for our purposes here today: the permanent increase in deductible health insurance costs for self-employed individuals; improvements in portability of private health insurance; and health care cost containment.

HEALTH INSUNNCE DEDUCTIBILITY

The cost of health insurance for the average architectural firm has at least doubled—and in some States quadrupled—in the past 5 years. Architectural firms are in a strange situation with regard to deducting the cost of health insurance. In many States, architects and other "professional service organizations" may not incorporate; 73 percent of the approximately 17,000 firms represented by the AIA's membership are not incorporated and so, under existing law, may deduct only 25 percent of the owner's health insurance costs. This is particularly onerous since 30 percent of these 17,000 firms are sole-proprietorships. Despite these facts, 64 percent of AIA firms offer medical insurance for their employees, and of that 64 percent, 79 percent pay the entire cost.

Mr. Chairman, I am sure you will not be surprised when I tell you that the AIA estimates that the percentage of firms providing insurance was 20 percent higher just 2 years ago. The Institute believes that this decline is continuing, and that it is picking up speed. I would like to submit for the record table 7.12 of the 1991 AIA Firm Survey. As you look at this statistical table, please keep in mind that 66 percent of the AIA's 17,000 firms consist of four employees or less. As you can see, the percentage of firms providing medical benefits dramatically decreases for smaller firms. Only 33 percent of single-member firms provide insurance, compared to 99 percent of firms with 20 or more employees.

Architects in solo practice in New York, California, Utah, Kansas, Florida, and nearly every other State in the union have called the AIA to express dismay that only 25 percent of their health insurance costs were deductible. One architect from Vermont called just last week to make sure her accountant wasn't in error.

Cost equals access for most small businesses. It is patently inequitable that small businesses are treated differently from corporations—many of which tend to be larger and are able to negotiate lower health insurance rates anyway—by virtue of their legal organization.

Of all the health care reforms currently being considered by Congress, a full 100 percent deduction for unincorporated businesses is one of the few areas of consensus. The philosophy behind the deduction is simple and tested: providing incentives to purchase health insurance works. The complete deduction for America's self-employed workers should be enacted as soon as possible as the first step to encourage wider coverage of working Americans.

HEALTH INSURANCE PORTABILITY

I would like to share with you some characteristics of the architectural profession:

- Architects tend to change jobs frequently—either by changing firms or by opening their own firms.
- The architectural profession is aging. The average age of an AIA member is 40+, and rising.

- Architects tend to work past age 65, when other American workers tend to retire. Many of the best known and most respected American architects are octogenarians, and are still designing award-winning structures.

These characteristics increase the likelihood of architects being unable to obtain or to afford health insurance coverage at some point in their lives. The firm to which an architect moves may not offer insurance. The architect may have a pre-existing condition that would deny him or her coverage. Illnesses or conditions associated with age could increase the cost of insurance, making it prohibitively expensive. It's no secret that the paperwork and red-tape associated with Medicare and Medicare supplements are health hazards themselves.

There is an architectural firm in Texas where the single principal, whose name the firm bears, is the only person left on a group indemnity program. The insurance company is now demanding 100 percent participation from the firm or the coverage will be terminated. Employees there pay their own premiums, and are all participants in an HMO not sponsored by the carrier of the firm's group plan. At age 60, after open heart surgery, the principal architect is uninsurable. He will more than likely soon be left without coverage.

Another architect left his position on the faculty of a major university to go into private practice, opening a firm of his own. His COBRA benefits were soon to run out and he was seeking insurance for his family, in particular for his 8-year old daughter who is diabetic. He expected her diabetes to be waived for a period, but he was concerned about other potential health problems because she is an active young girl, attending school and participating in youth soccer. He could find no coverage for her at all.

The AIA believes that S. 1872 adequately addresses the problem of portability, and will allow millions of heretofore uninsured Americans to gain access to care through insurance coverage.

HEALTH CARE COST CONTAINMENT

The AIA's best estimate is that design firms devote about 8 percent of their annual payroll costs to health benefits—in many firms the second largest business expense after salaries. According to the J. Foster Higgins annual health benefits survey, the cost of health insurance can be the greatest payroll line-item cost for a business, exceeding the combined cost of workers compensation and general liability insurance.

The Institute, along with many other trade and professional associations, has attempted to combat the high cost of insurance for its members by organizing its own insurance trust to represent architects in negotiating with insurance carriers. Approximately 7 percent of the AIA's member-owned firms are currently covered by the AIA Trust's health plan. Several State AIA chapters—including Texas, Pennsylvania, and California—have organized their own "Trusts," covering another 7 percent of the AIA's member-owned firms. The AIA Trust programs cover a total of about 13,000 people.

The AIA Trust provides a necessary service for thousands of AIA members and their families who otherwise would not be able to afford or to obtain insurance. People over the age of 55, in particular, are paying unbelievably high premiums. A 57-year old architect from Kansas called the AIA Trust recently to see if there was any relief from the almost $10,000 annually he is paying for 30-70 coverage for himself and his wife. The AIA Trust was able to offer them lower premiums for better coverage, but the amount was still a significant percentage of their annual budget.

We are concerned that some of the provisions of S. 1872 may jeopardize these association-based plans. A literal interpretation of this bill could force our national plan to offer coverage to non-architects in any geographical area in which we currently have participants. Obviously this would destroy the primary purpose and value of the plan, which is to offer the kind of coverage that architects need.

Professional and trade associations can play an important role in the planning and implementation of any changes to the current health care delivery system. Needs assessment, ability to pay based on the industry, and other information can be provided by such organizations. Education of members, something we have already begun at the AIA, could be extended to notifying members of any changes to the health care delivery system. We would respectfully ask you and your committee to examine the provisions of S. 1872 that would inhibit the ability of associations to offer health insurance plans.

Aside from this concern, the AIA endorses your efforts to control the cost of health care. We would suggest that in addition to the duties already outlined in your bill for the Health Care Cost Commission, you might consider adding an examination of the efficiency and consistency of the State bureaucracies in dealing with health

insurance. When the AIA Trust offered a new, improved insurance plan to its members, it took almost a year for the 50 States—each moving at its own speed and with no sense of urgency—to grant final approval of the plan. This could prove to be a major stumbling block to the implementation of any improvements your legislation would offer.

The authorization of funds for additional outcomes research is an important component of bringing the discipline of the market to health care purchasing. Better informed consumers and providers will vastly improve the current health care delivery system.

Mr. Chairman, S. 1872 offers readily-enactable, market-based solutions to America's health care crisis. Its provisions would promote affordable health care without compromising the quality of care that Americans have come to expect. I would like to offer the resources of the AIA and its membership in seeing this legislation enacted and implemented. Again, we appreciate this opportunity to testify, and I'll be happy to answer any questions that the members of the Committee might have.

7.12.—PERCENTAGE OF FIRMS PROVIDING EMPLOYEE BENEFITS BY FIRM SIZE

| | 1 | 2–4 | 5–9 | 10–19 | 20+ | All firms |
|---|---|---|---|---|---|---|
| Medical Insurance: | | | | | | |
| Firms Providing Benefit | 33% | 65% | 90% | 96% | 99% | 64% |
| 100% Paid by Firm | 85 | 80 | 80 | 79 | 65 | 79 |
| Contributory | 15 | 20 | 20 | 21 | 35 | 21 |
| Dental Insurance: | | | | | | |
| Firms Providing Benefit | 9% | 16% | 30% | 42% | 54% | 21% |
| 100% Paid by Firm | 86 | 73 | 72 | 66 | 51 | 70 |
| Contributory | 14 | 27 | 28 | 34 | 49 | 30 |
| Eye-Care Insurance: | | | | | | |
| Firms Providing Benefit | 5% | 8% | 12% | 17% | 21% | 9% |
| 100% Paid by Firm | 86 | 74 | 67 | 69 | 63 | 72 |
| Contributory | 14 | 26 | 33 | 31 | 37 | 28 |
| Life Insurance: | | | | | | |
| Firms Providing Benefit | 16% | 30% | 53% | 69% | 87% | 36% |
| 100% Paid by Firm | 87 | 84 | 83 | 83 | 82 | 84 |
| Contributory | 13 | 16 | 17 | 17 | 18 | 16 |
| Long-Term Disability Insurance: | | | | | | |
| Firms Providing Benefit | 11% | 14% | 20% | 390% | 63% | 19% |
| 100% Paid by Firm | 87 | 84 | 75 | 82 | 82 | 82 |
| Contributory | 13 | 16 | 25 | 18 | 18 | 18 |
| Short-Term Disability Insurance: | | | | | | |
| Firms Providing Benefit | 6% | 8% | 15% | 17% | 31% | 11% |
| 100% Paid by Firm | 84 | 75 | 75 | 88 | 82 | 79 |
| Contributory | 16 | 25 | 25 | 13 | 18 | 21 |
| Defined-Contribution Retirement Plan: | | | | | | |
| Firms Providing Benefit | 11% | 14% | 19% | 32% | 66% | 18% |
| 100% Paid by Firm | 86 | 75 | 71 | 55 | 36 | 66 |
| Contributory | 14 | 25 | 29 | 45 | 64 | 34 |
| Defined-Benefit Retirement Plan: | | | | | | |
| Firms Providing Benefit | 3% | 6% | 10% | 18% | 24% | 8% |
| 100% Paid by Firm | 81 | 70 | 76 | 93 | 83 | 80 |
| Contributory | 19 | 30 | 24 | 7 | 17 | 20 |
| Dependent Medical Insurance: | | | | | | |
| Firms Providing Benefit | 20% | 41% | 69% | 80% | 93% | 46% |
| 100% Paid by Firm | 75 | 57 | 44 | 33 | 19 | 48 |
| Contributory | 25 | 43 | 56 | 67 | 81 | 52 |
| Dependent Dental Insurance: | | | | | | |
| Firms Providing Benefit | 5% | 11% | 23% | 35% | 48% | 16% |
| 100% Paid by Firm | 74 | 51 | 38 | 26 | 12 | 39 |
| Contributory | 26 | 49 | 62 | 74 | 88 | 61 |
| Dependent Eye-Care Insurance: | | | | | | |
| Firms Providing Benefit | 3% | 5% | 10% | 15% | 17% | 7% |
| 100% Paid by Firm | 81 | 45 | 31 | 26 | 13 | 38 |
| Contributory | 19 | 55 | 69 | 74 | 88 | 62 |
| Dependent Life Insurance | | | | | | |
| Firms Providing Benefit | 7% | 11% | 15% | 22% | 24% | 12% |

7.12.—PERCENTAGE OF FIRMS PROVIDING EMPLOYEE BENEFITS BY FIRM SIZE—Continued

| | 1 | 2-4 | 5-9 | 10-19 | 20+ | All firms |
|---|---|---|---|---|---|---|
| 100% Paid by Firm | 78 | 48 | 22 | 29 | 23 | 41 |
| Contributory | 22 | 52 | 78 | 71 | 77 | 59 |



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PREPARED STATEMENT OF MILDRED MCCAULEY

Good morning. My name is Mildred Mccauley and I am from Myrtle Creek, Oregon. I am a member of the Board of Directors for the American Association of Retired Persons. I am pleased to have the opportunity to appear before the Committee today to discuss the need for Medicare coverage of preventive services.

Let me begin by commending you Senator Bentsen, and the Committee, for holding this hearing. Your exploration of insurance market reform and your efforts to address one of the most serious deficiencies in the Medicare program—a lack of coverage for preventive health care—are both small but important steps toward comprehensive health care reform. while my testimony today will focus on the need for expanded preventive care in the Medicare program, I would be remiss if I did not say initially that the Association believes firmly that our Nation's health care system needs major reform to enable it to provide affordable, quality health care to individuals of all ages. The insurance market reforms and the Medicare expansions being discussed today are steps in the right direction, but they must be a part of a larger strategy that will retool our fragmented, expensive and increasingly deficient health care system.

INSURANCE MARKET REFORMS

Roughly one half of AARP's members are between the ages of 50 and 65. Recent surveys tell us that it is this group that is most concerned about reforming our health care system, as well as losing their own health insurance. Many of these individuals retired early believing that their retiree health benefits were assured, only to find their benefits reduced or even canceled. Others, including many small business owners, are being priced out of the health insurance market.

Insurance market reforms are inadequate by themselves to make insurance more widely available and to contain health care costs, but they are an important compliment to broader reform. We would be pleased to work with this Committee over the next month to help develop a package of insurance market reforms that provides real benefits to consumers. We want to take this opportunity today to urge you to include in that package strong consumer protections that ensure that purchasers receive real value for their insurance premium dollar.

In this regard, I want to emphasize the importance of including consumer protection standards for long-term care policies in S. 1872, along with the market reforms for acute care health insurance.

In the absence of comprehensive long-term care legislation, and in light of the increasing numbers of Americans who are turning to private long-term care insurance to protect themselves against the high costs of long-term care, the Association believes that efforts to create uniform Federal consumer protection standards for long-term care policies are essential. Unless the Federal government takes action, consumers will waste millions of dollars on long-term care policies that fail to provide real benefits. Recent studies by the General Accounting Office, the Inspector General and Project HOPE have confirmed that few States are doing an adequate job of enacting and enforcing consumer protection standards in this area. It is our hope that legislation will be enacted into law during this Congress which accomplishes the following objectives:

- protects consumers against policies that are not likely to ever provide benefits, even if the need arises;
- assures that these products are marketed and sold in a fair and informative manner;
- collects data that enables assessment over time of the real value of long-term care insurance policies to consumers; and,
- eliminates policy limitations and restrictions that cause confusion and significantly reduce the value of policies.

PREVENTIVE HEALTH CARE

My own experience with breast cancer has indelibly impressed upon me that preventive care not only saves the expense of costlier treatments that are required if a serious illness goes undetected—it can also save lives. Unfortunately, early detection is often not an option for millions of older Americans who have no coverage for even the most basic preventive care services.

Medicare's lack of coverage for preventive health care is more than a financial drawback for older beneficiaries; it is a symptom of a much greater problem—a seriously disjointed and increasingly expensive health care system. Millions of Americans are now finding that their health care coverage is alarmingly inadequate. Millions more—many of whom are working men and women and their families—have no access to health care coverage at all. While most older persons rely on the Medicare program, serious gaps in coverage, such as prescription drugs, are undercutting the financial protection it provides.

The root of the problem is the uninhibited growth in health care costs. The phenomenal increase is health care costs over the past several years has created an ever increasing barrier to access.

The increasing vulnerability of all Americans, regardless of age or income, underscores the need for broader health care reform. AARP is committed to achieving a health care system that ensures all individuals access to affordable medical and long-term care. We view incremental steps—such as the coverage of preventive care services under Medicare—as one way of moving us closer to the goal of comprehensive reform, so long as those incremental steps are consistent with an overall blueprint for comprehensive reform.

The Association's testimony will focus on four specific issues:

(1) the effect of rising health care costs on older American's ability to seek preventive care;

(2) the importance of the benefits included in the Better Access to Affordable Health Care Act of 1991, S. 1872;

(3) financing the new and expanded benefits; and,

(4) Medicare coverage of preventive care as an incremental step toward comprehensive reform of the health care system.

RISING HEALTH CARE COSTS

Older Americans currently spend approximately 15 percent of their yearly income on health care—roughly the same percentage they spent before Medicare was enacted. The extraordinary increase in health care costs is the primary reason for this dramatic rise in out-of-pocket payments.

In 1990, health care expenditures in the U.S. totalled approximately $666 billion, an increase of 10.3 percent over 1989. Over the last decade, health care costs have increased, on average, 11 percent annually. These cost increases have significantly widened the gap in Medicare's protection of beneficiaries.

In addition to the steady rise in premiums and the cost of coinsurance, rising health care costs have translated into higher out-of-pocket expenses for services not covered by Medicare. For every dollar beneficiaries spend on Medicare services, they spend another fifty cents to one dollar on non-covered services like preventive health care. For many older persons, and particularly those with lower incomes, these costs become a barrier to important preventive services.

THE NEED FOR COVERAGE OF PREVENTIVE CARE

Detecting an illness before it becomes life-threatening is one of the greatest benefits of preventive health care. The American Cancer Society estimates for instance, that with early detection, about 87 percent of individuals, compared to the current two-thirds, who contract the more treatable types of cancer—including breast cancer and colorectal cancer—would survive. This means that of those people who were diagnosed with cancer in 1991, nearly 100,000 more would live if their condition had been detected earlier. For older Americans, access to preventive services is particularly important given that age is often the most significant risk factor in contracting many diseases.

Another advantage of preventive care is avoiding the necessity of costlier treatments. For example, a Congressional Budget Office analysis of Medicare coverage of annual mammography screening cited studies which found that the cost of treating breast cancer detected at an early stage is less than the cost of treatment once the disease has progressed.

The recognition that preventive care is gaining an increasingly important role in our health care system is evidenced by a recent health care reform survey conducted

for AARP by DYG, Inc. This survey, of 1,400 people age 18 and older, found that there is a strong public preference—expressed by Americans of all ages—for a health care system that includes preventive health care. In fact, when asked to rank the relative importance of key components of a health care program, survey participants ranked preventive care, whether as part of a "basic health plan" or more generous "enhanced medical coverage," second only to their concerns about the factor of "cost/willingness to pay."

THE BENEFITS IN S. 1872

The Better Access to Affordable Health Care Act of 1991, S. 1872, would provide Medicare coverage for some of the more widely recommended preventive care services.

*Annual Mammography Screening*

Breast cancer is the most frequently occurring cancer in women, and is the second leading cause of cancer deaths among women today. This year alone, one in nine American women will develop this disease. Older women are the most vulnerable. With early detection, however, the survival rate of localized breast cancer is an astonishing 91 percent.

I myself have survived breast cancer. My condition was detected through a physician's examination and mammograms. Because the disease was diagnosed at an early stage, the cancer was successfully eliminated. I now have a clean bill of health and have resumed an active life. I can tell you first hand that preventive care is a life saving benefit.

The current Medicare mammography benefit provides only biennial coverage for women over the age of 64. S. 1872 would allow Medicare beneficiaries over the age of 50 to receive annual mammography screening. while there is still a lack of comprehensive age-specific research on the appropriate frequency of mammography screening for older women, age is a well documented risk factor. In light of this, the American Cancer Society and the National Cancer Institute recommend annual mammograms for women over the age of 50 and AARP recommends that women follow this guideline.

*Colorectal Cancer Screening*

Each year, over 100,000 people 65 years of age and older are diagnosed with colorectal cancer. In fact, nearly three out of every four new cases of colorectal cancer occur in older persons. Age is one of the strongest risk factors associated with this disease. According to the Office of Technology Assessment, the incidence of colorectal cancer in men 50 years of age is 57 per 100,000. By the age of 65, the incidence rises to 244 per 100,000, and by 75 years old it is 411 cases per 100,000. while women have lower rates of colorectal cancer, the incidence still increases with age.

When colorectal cancer is detected at an early stage, the rate of survival is very encouraging—88 percent for colon cancer and 80 percent for rectal cancer. Yet the two most commonly recommended tests for detection of this disease—a stool blood slide and proctosigmoidoscopy—are not covered by Medicare.

S. 1872 provides coverage for colorectal cancer screening. Coverage of these two important preventive tests will enable thousands of Medicare beneficiaries to better safeguard their health.

*Immunizations*

For most Americans, an onset of the flu is not a serious condition. But for some, particularly older persons, influenza is often life-threatening. The Centers for Disease Control estimate that a typical flu epidemic will cause over 20,000 deaths, and most of these will be individuals over the age of 65. Both the Centers for Disease Control and the American College of Physicians recommend flu vaccines for persons over the age of 65, yet Medicare does not cover this service for all beneficiaries.

Congress recognized the importance of making flu vaccines available to older Americans when it approved a vaccine demonstration project as part of the Omnibus Budget Reconciliation Act (OBRA) of 1987. If the vaccine proved to be cost-effective, the law provided that Medicare would be expanded to include coverage of the benefit. Unfortunately, the initial report on the project, which was due in 1990, was not released, and Medicare coverage of flu vaccines remains limited to those individuals participating in pilot projects.

Since it is not clear when the report's findings will become available, only a small number of beneficiaries enjoy this protection. S. 1872 would provide Medicare coverage of yearly flu vaccines nationwide, thereby ensuring that all beneficiaries are protected from a potentially serious condition.

*Well-Child Care for End Stage Renal Disease (ESRD) Beneficiaries*

The Medicare program currently provides coverage for qualified children with End Stage Renal Disease (ESRD). These children are eligible for all Part A benefits, including transplants, as well as Part B services. Yet Medicare's lack of preventive coverage means that these children can receive care only for renal failure, not for the basic preventive care necessary to otherwise ensure their overall good health.

S. 1872 would remedy this problem for the approximately 500 children under the age of seven who are Medicare ESRD beneficiaries. In addition to their current Medicare benefits, these children would also be covered for routine immunizations, office visits and routine lab tests.

Including coverage of preventive services for younger ESRD Medicare beneficiaries is a logical step. Medicare already covers the services associated with end stage renal disease, yet without good basic care, many of these other services are not as effective as they could be. This improvement in Medicare will ensure that a particularly vulnerable population of beneficiaries has access to greatly needed care.

*Preventive Care Demonstration Projects*

S. 1872 also establishes a series of preventive care demonstration projects to examine the feasibility of expanding Medicare coverage for additional preventive care services. Given the debate over the effectiveness of certain preventive care benefits, such as osteoporosis screening, AARP believes that establishing demonstration projects is a prudent way to determine the appropriateness of additional benefits in the Medicare program. At the same time, we do not believe that demonstration projects, like the OBRA '87 influenza study noted above, should become a convenient device to further delay consideration of a broader Medicare benefit.

We are very pleased that one of the demonstration projects included in this provision is a one-time comprehensive health assessment for older individuals. General physical examinations are the foundation for maintaining good health yet are not covered by Medicare. This means that many older persons often do not seek care until symptoms of an illness exist. By that time a preventable condition may have worsened and the risk of higher health care costs is greater. AARP believes that health assessment should be part of any comprehensive preventive health care program.

*Office of Technology Assessment (OTA) Study*

AARP is also pleased that the legislation requires the Office of Technology Assessment (OTA), after conducting a study, to recommend a process for determining the criteria to be used in making Medicare decisions for additional preventive services.

AARP believes that this type of study is necessary. while the Association supports coverage of preventive care under Medicare, we believe that tests of appropriateness and effectiveness must be applied to coverage of preventive services, just as they should be applied to the rest of the health care system. Preventive screening techniques should not be used simply because they are available, but because they are an effective means of detecting and preventing an illness.

*Financing*

S. 1872 does not include a specific method for financing the new and expanded preventive care benefits. Given the current budget rules, the lack of a financing mechanism raises some concerns.

The Association views the traditional financing of Medicare Part B—which spreads the cost of the program across the entire population—as the most appropriate financing structure for new Medicare benefits.

Some have suggested that this structure results in upper income beneficiaries receiving undue benefits at the expense of general taxpayers. With the exception of low-income Qualified Medicare Beneficiaries (QMBs), all Medicare beneficiaries pay approximately 25 percent of program costs through premiums, but what is often ignored is the fact that over half of the 33 million Medicare beneficiaries also subsidize the Part B Trust Fund by paying Federal income tax. Of total income tax paid by individuals, roughly 9 percent finances Medicare Part B (assuming that the general fund revenues designated for Part B come entirely out of individual Federal income tax). In short, Medicare beneficiaries who are more fortunate than others help support those who are less fortunate.

## CONCLUSION

AARP applauds your efforts to close some of the existing gaps in the Medicare program by expanding coverage for preventive health care. This is an important incremental step towards broadening access. However, the Association believes that

each incremental step should move us closer to the overall goal of comprehensive health care reform. As a Nation, we can no longer afford to continue a piecemeal approach towards health care.

AARP recognizes that broad public consensus will be key to achieving a health care system that provides access to both acute and long-term care services for all individuals. It is not enough to simply express unhappiness with the current system, as most surveys today show. It is equally, if not more important, for the public to understand that there are choices, trade-offs and costs associated with reforming the health care system. That is why continued public education is essential. Only by educating the public about the need for change and the choices that must be made can we expect to achieve a broad consensus.

Clearly the Association cannot build a broad public consensus on its own. It is incumbent upon the Administration and a bi-partisan Congress, as well as AARP and other groups, to lay the groundwork that will focus public attention on the tough questions and tradeoffs that must be part of the solution, such as:

- What elements of a health care system are most important to Americans?
- Are we willing to make the tradeoffs that will be necessary to ensure access for all Americans?
- Are we willing to pay the cost of these benefits, not only in the aggregate, but as individual taxpayers?

These questions—which ultimately focus on how a reformed health care system would be financed and on Americans' willingness to pay for such reform—will be at the center of the debate.

The 1992 elections will offer an important opportunity to help inform the public about the choices and costs of reforming our health care system.

AARP, through the efforts of our volunteer leaders around the country, is working to ensure that the 1992 elections are a forum for a national debate on health care reform.

Mr. Chairman, thank you for the opportunity to testify today. AARP looks forward to working with you and this committee to make health care reform a reality.

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PREPARED STATEMENT OF JOHN J. MOTLEY, III

Mr. Chairman, my name is John Motley, and I am the Vice president of Federal Governmental Relations for the National Federation of Independent Business (NFIB). NFIB is the Nation's largest small business advocacy organization, representing more than 500,000 small and independent business owners Nationwide.

Thank you for this opportunity to testify before the Finance Committee on S. 1872, the Better Access to Affordable Health Care Act, introduced by Chairman Bentsen, Senator Durenberger, and 21 other members of this Committee.

THE STATUS QUO IS UNACCEPTABLE

The cost and availability of health insurance is the number one problem facing the Nation's small business community. It has grown to such proportions over the last decade that **the status quo is no longer acceptable.** America's small business owners need relief from rapidly rising health insurance bills, and they need it in 1992. Neither they nor their employees can afford to wait until after the November election, or even worse, until after the political debate surrounding the health care issue is completely decided.

Small business concern about health insurance first surfaced for NFIB in 1986 when it finished number one out of 75 potential problems presented to our members. In the NFIB Foundation's in-depth study, *Small Business and Health Care* completed in 1990, 92 percent of the respondents said that health insurance was "a serious business problem." In the soon-to-be-released 1992 follow-up to our 1986 survey, *Problems and Priorities,* the cost of health insurance is still the number one problem, but it is now twice as critical as number two, which is "Federal taxes on business income." Between 1987 and 1991, the cost of health insurance for a single employee rose 79 percent and for family coverage 72 percent. According to Forster and Higgins, the average per employee cost of health insurance in 1991 was over $3,100. All of these figures are considerably higher for the typical small business.

For years, employers of all sizes have been trying to find ways to control and slow these rapid increases. Larger firms and insurers have instituted cost containment strategies like managed care. Almost all employers have tried spreading the pain by increasing employee deductibles and co-payments. None of these steps have been very effective. In our 1990 study cited above, 91 percent of the respondents reported that the cost of health insurance was "becoming prohibitive, expensive."

Continued rapidly rising medical costs and the steps employers have taken to try to control them have led to increasing middle-class fear. NFIB members are typical. They are deeply concerned that they will not be able to afford to provide health insurance for their employees or even their own families.

It was middle-class fear that reared its head last November in Pennsylvania, and it is middle-class fear that shows up in almost every poll taken. In fact, middle-class fear has replaced access for the uninsured as the driving force behind health care reform, and it is the reason why S. 1872 is a very important piece of legislation.

For years, there has been a growing consensus that past government actions have thrown both the health care and health insurance marketplaces into turmoil. And while there remains strong differences of opinion on how to deal with health care and access for the uninsured, there appears to be broad agreement on the steps that need to be taken to correct the health insurance market.

From Senator Kennedy to President Bush and from Senator Chafee's S. 1936 to Chairman Bentsen's S. 1872, there is consensus or near consensus on a number of reforms. From 100 percent deductibility for the self-employed to insurance market reforms and from preemption of State mandates to small business insurance purchasing groups, there is agreement. Whether someone calls these changes "a first step," "a down payment on reform" or an "incremental solution," they need to be made now, in 1992, before the 102nd Congress adjourns.

For some time, these needed and agreed upon reforms have been held hostage by those who believe that they should only be included as part of a larger, more comprehensive solution. If they are enacted by themselves, so the argument goes, the momentum for a more radical solution diminishes, putting comprehensive reforms off indefinitely. Therefore, these changes need to be held back, as hostages, to extract business community or moderate support for the more radical approach.

The problem with this argument is that none of the so-called comprehensive or universal solutions on either the left or the right, from a single payer system to complete individual responsibility, have any chance of being enacted and signed into law anytime soon. The opposing forces are firm in their beliefs and politically potent. Therefore, none of these more grandiose solutions can be enacted until the political debate is over, and the business community, particularly the small business community, cannot wait that long. As I stated in the beginning of my testimony, *the status quo is no longer acceptable to the American business community.*

Because the health insurance crisis demands immediate attention, NFIB commends Chairman Bentsen, Senator Durenberger, and the other cosponsoring members of this Committee for introducing S. 1872, which combines in one piece of legislation many of the consensus steps that need to be taken in 1992. If S. 1872 is enacted, it will reduce middle-class fear by stabilizing the health insurance marketplace. It will begin to address the problem of the uninsured by providing access and incentives to small business owners who have been frozen out of the health insurance market by cost. It will equalize treatment between employers and take the first needed steps toward effective cost containment.

NFIB urges quick action on S. 1872 or similar legislation. We strongly support its enactment and hope that the Committee and the Administration will reach agreement quickly so it can be signed into law before the 102nd Congress adjourns.

### VIEWS ON S. 1872

While NFIB supports S. 1872, there are some sections that we favor more strongly than others and some we have concerns about. Below is a discussion of these sections, plus our recommendations for additions to the bill:

*Strongly Support*

*Parity for the Self-Employed*—There is absolutely no reason why self-employed business owners should not have the same tax deduction for health insurance that corporations have. If they did, many of the 4.8 million (estimate) uninsured, self-employed would purchase health insurance not only for themselves, but also for their estimated 4.6 million employees. With this simple act of parity, increasing the deduction for health insurance premiums for the self-employed from 25 to 100 percent, a significant portion of the problem of the uninsured can be addressed.

*Small Business Insurance Market Reform*—To the severe detriment of small business, the health insurance marketplace has changed dramatically since the enactment of ERISA. Today 59 percent of insured workers are employed by firms that self-insure, leaving only small, Main Street businesses exposed to the changing practices of a fragmented health insurance market. These small firms are subject to State mandates and premium taxes, medical underwriting, huge administrative costs, unilateral decisions, bait-and-switch tactics and high premium increases. Many can't find insurance, and those that can, worry that they won't be able to af-

ford it in six months. The insurance market reforms in S. 1872 should stabilize the health insurance marketplace for small firms. Availability, renewability, and portability will be guaranteed, and only reasonable rate increases will be allowed.

*Preemption of State Mandates and Basic Care Policies*—Even with the changes in S. 1872, many small, marginal firms would not be able to afford the Cadillac health insurance policies prescribed by States through legislated (mandated) coverage. In many States such as Maryland, which has 33 legislated coverages, these mandates price the small employer out of the market. Studies clearly show that there is a progression in fringe benefits and levels of coverage as firms mature and grow profitable. The public policy goal of Congress should be a low cost, basic policy that can be marketed nationally so that newer firms can afford to provide a minimum level of coverage for their employees as soon as possible. When the only option available is a Cadillac plan, requiring 30 to 35 expensive benefits, coverage of employees is delayed and may never happen. The preemption of State mandates will allow the insurance industry to design and market this type of policy, increasing the likelihood that small businesses will be able to purchase them.

*Small Business Purchasing Groups*—Experiments with purchasing groups that, in effect, allow small firms to band together and self-insure are very encouraging. They have real potential for reducing the cost of coverage to a level that many Main Street size firms can afford. Done properly, they not only side-step State mandates and premium taxes, but cut administrative and medical costs.

*Concerns*

*Minimum Standard Packages*—The key to finding a solution for small firms is lowering the cost of a policy to the point where it is truly affordable. Standard benefit packages, like the ones in S. 1872 and Senator Kennedy's "play-or-pay" proposal, badly miss the mark. While they may not be Cadillac plans, they include expensive coverages, such as mental health care and drug and alcohol abuse, and limitations on cost sharing by employees. It appears that they are designed to fail because they will be priced beyond the ability of many small firms to pay for them.

In addition, a standard plan set in law just begs to become the target of legislative gamesmanship. After all, that is how the current system developed over 800 State mandates. For these reasons, NFIB is strongly opposed to legislated standard plans. It is one of the major flaws in "play-or-pay." Fortunately, S. 1872 also provide; for basic health insurance plans designed from categories of coverage. While NFIB prefers to have the design decision completely in the hands of insurers, the basic plan options in S. 1872 seems to be a workable compromise.

*Preemption Only For Small Business Market*—As inferred above, NFIB prefers the complete preemption of State mandated coverage. The ultimate goal of insurance market reform should be the freedom for an insurer to design a basic or essential care package that can be marketed and sold to NFIB's 500,000 members in all 50 States (one in every nine employers in the United States) through our magazine. So long as State and/or Federal legislative or regulatory schemes prevent this, we believe that they are counterproductive to sound public policy.

*Rating Bands*—NFIB simply does not have enough technical expertise to be comfortable that rating bands will work in the best interests of small business health insurance purchasers. They appear to be a workable compromise between the current, unacceptable system of underwriting and a return to community rating, which insurers oppose. Loose bands, which the industry favors, could work against small firms, while tighter bands could inhibit the operation of the market. Since this is such a technical area, we urge that its impact be monitored closely.

*One Person Businesses*—NFIB appreciates the Chairman's effort to expand the scope of small business market reforms to encompass firms with two to fifty employees. Unfortunately, this still leaves one person—the owner—firms out in the cold. NFIB realizes that there are significant problems, such as adverse selection, in covering one-person firms, but we urge the Committee to continue to search for ways to include this group of business owners.

*Additions for Consideration*

*Medical Malpractice Reform*—In testimony after testimony, NFIB has stated that insurance market reform cannot be successful without effective medical cost containment. Medical inflation is the root of the health insurance market problem, and to reform the latter without controlling the former is like putting a bandaid on a bullet wound. S. 1872 takes a first step toward cost containment by dealing with restraints on managed care and encouraging outcomes research, but more needs to be done now not later. NFIB strongly urges the Committee to include effective medical malpractice tort reforms in whatever vehicle it takes to the floor. Without action in this area, there is little hope of curtailing the practice of expensive defensive medicine

or of reducing the exorbitant medical malpractice insurance rates practioners must now pay.

*Small Business Purchasing Groups*—S. 1872 provides for grants for a number of State pilot programs to test small business purchasing groups. This, as mentioned earlier, is an innovation with real promise for small firms, but the recent announcement by the President of his proposal, which features small business Health Insurance Networks (HINs), may provide an opportunity to go farther, faster. NFIB urges you to explore this option with the Administration and other interested parties to see if the timetable for action in this area can be advanced.

### CONCLUSION

NFIB strongly supports S. 1872 because it effectively addresses the most critical problem facing small business owners today, the availability and cost of health insurance. It combines a series of reforms around which a positive consensus has already developed into a single, passable piece of legislation.

S. 1872 will stabilize the small business health insurance marketplace and make affordable insurance choices available to small business owners. It will equalize tax treatment among different types and forms of businesses and provide real incentives to small business owners to purchase health insurance for themselves and their employees. In addition, it begins the process of addressing the problem of medical cost containment.

NFIB supports S. 1872 because it recognizes that the status quo in health care is no longer acceptable to the business community and moves to deal with this problem in a reasonable, logical and passable way. American small business needs relief in 1992, and we urge this Committee to explore areas of agreement with the Administration and move legislation that can be signed into law by the President before the 102nd Congress adjourns.

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## Prepared Statement of Dick Niemiec

Mr. Chairman and Members of the Committee, I am Dick Niemiec, Senior Vice President for Underwriting, Actuarial and Legal for Blue Cross and Blue Shield of Minnesota. Blue Cross and Blue Shield of Minnesota provides health benefit protection for over 1.1 million Minnesotans through our managed care arrangements, including our HMO affiliate, Blue Plus. We are one of 73 non-profit Blue Cross and Blue Shield Plans across the country. The local nature of our organization allows us to respond to varying State environments and the unique needs of employers and individuals.

I welcome the opportunity to address the Committee on the issue of reforming the health insurance market for small employers. In my testimony today, I will give the Committee a brief overview of the Blue Cross and Blue Shield System's position on small group market reform, and then comment on S. 1872, the "Better Access to Affordable Health Care Act," introduced by Chairman Bentsen last year.

### BLUE CROSS AND BLUE SHIELD POSITION

The Blue Cross and Blue Shield System believes that reform is needed in the small group insurance market to assure that all small employers can purchase coverage, regardless of their health status or past claims experience, and to stabilize premiums charged to small employers. We support enactment of these needed reforms. We also recognize that insurance reform must be a key element of any proposal to assure universal access through a pluralistic system.

In January of last year, the Board of Directors of the Blue Cross and Blue Shield Association adopted a small group insurance reform proposal. This proposal would:

- Assure that small employers have access to private insurance, regardless of health status, occupation or location;
- Assure that States have a range of options to choose from in providing for the availability of private insurance to small employers;
- Assure that small group coverage is provided at fairly established rates;
- Assure that no small employer is dropped from coverage because of poor claims experience;
- Assure continuity of coverage for individuals changing employers or small employers changing insurers;
- Assure the adequate, effective enforcement of all insurer requirements; and
- Assure the availability of lower-cost products.

With respect to assuring small employers access to private insurance, we believe that States should have the flexibility to choose an approach that meets the needs of their environments. One approach that has received a lot of attention would require all insurers to offer coverage to small employers on a guaranteed issue basis and would establish a private reinsurance mechanism to help insurers spread the costs associated with high-risk groups.

While this approach may be appropriate in some States, we believe it is equally important for States to be able to choose approaches that do *not* rely on guaranteed issue and a reinsurance mechanism. Many carriers believe that guaranteed issue is feasible only if a reinsurance mechanism is in place to redistribute the costs of high-risk small employers. Yet, reinsurance is highly complex, it has not been tested in any State, it will be costly to administer and difficult to enforce, and it likely will require additional subsidies beyond the small group market.

Approaches other than guaranteed issue that meet the goal of assuring access to private insurance should be permitted, including:

- An allocation approach, whereby high-risk small employers would be distributed equitably among all carriers in the small group market; and
- A voluntary guaranteed issue carrier(s) approach, whereby a carrier or carriers would voluntarily provide coverage to all small employers on a guaranteed issue basis.

These alternative programs would assure that all small groups have access to private coverage and that all insurers meet the general principals I just discussed.

"BETTER ACCESS TO AFFORDABLE HEALTH CARE ACT"

We congratulate you, Mr. Chairman, for recognizing that the problems in this market need to be addressed. We support many of your bill's provisions. Our primary concerns with the bill, which I will discuss in detail, involve the rating provisions, regulatory framework and scope.

We support your bill's recognition of the need for State flexibility in assuring availability of private insurance coverage for small employers. We also support your provisions on renewability, guaranteed eligibility for all employees in a group, carrier registration, disclosure and actuarial certification.

In addition, we support your recognition of the importance of managed care programs, and the proposed pre-emption of State laws that limit managed care arrangements for programs meeting certain standards. In Minnesota, managed care programs have long been a central part of our cost management strategy.

Our managed care programs address the appropriateness and outcomes of services provided to our subscribers. We examine physician practice styles through sophisticated data collection systems. We use this information both to select high quality, cost effective providers for our managed care networks and to improve the quality of care and health outcomes of our subscribers.

For example, we studied hospital admission patterns in Minnesota for heart attacks and found one county with admission rates that were 82 percent higher than the rest of the State. In response, we launched an aggressive community health program with doctors in the county to educate and screen residents for risk factors for heart disease. We also reviewed mammogram screening practices in our clinics and found wide disparities in the percentage of women screened, ranging from 75 percent at one clinic to as few as 18 percent at another. To address this disparity, we are working with the clinics providing too few mammograms to increase the use of this important procedure.

This type of managed care has resulted in lower rates of inflation for our employer groups. For example, the State of Minnesota moved its indemnity coverage for its employees to a unique managed care program through Blue Plus. The result has been rate increases of less than six percent for the past several years.

The effectiveness of managed care is confirmed in a survey conducted by A. Foster Higgens, a national employee benefits firm, which reported that Minnesota businesses paid premiums 18 percent less than the national average. Much of the reason for these lower costs can be explained by the prevalence of managed care coverage in Minnesota—approximately 60 percent of residents are covered in managed care arrangements.

For these reasons, we fully support the provisions in S. 1872 that would further encourage managed care arrangements. We do, however, have concerns with some other provisions and would recommend the following changes.

**Rating Requirements.** Our key concern is with the rating limits in the bill. While the rating limits recognize the need for carriers to have some flexibility to adjust small employers' rates for health status and claims experience, we believe the

limits may be too restrictive and thus may result in substantial rate increases for many small employers. In particular, we are concerned that the 5 percent cap on rate increases for experience or health status is too strict.

For these reasons, we are opposing rating restrictions that are tighter than those recommended by the National Association of Insurance Commissioners (NAIC) in its model act on rate regulation. In a voluntary environment, where there is no employer mandate, restrictive rating requirements such as the community rating provisions supported by many Members would result in significant rate increases for many small employers. As a result, many of these employers could drop coverage rather than pay the higher costs.

While S. 1872 does not require community rating, we know that some Members are supporting a requirement that insurers community rate their small group business. To get an idea of the magnitude of rate increases small employers could face under such requirements, Blue Cross and Blue Shield Association staff worked with actual data from six Blue Cross and Blue Shield Plans. Based on this analysis, about half of all small employers would receive rate increases under community rating proposals that would not permit adjustments for demographic variables such as age and sex. While the increases would vary, some small employers would see their rates increase by over 100 percent. The analysis showed that half of the subscribers for these six plans would receive a very significant rate increase to subsidize the rest of our enrollment.

It's Important to note that rate increases resulting from community rating requirements would be only part of the overall rate increase small employers would face under reform proposals. Other factors that would increase rates include health care cost inflation as well as the added costs of the guaranteed availability requirement. Several State-level studies have estimated the cost of a guaranteed issue requirement at about 10 percent. This added cost is a result of making coverage available to high-risk small employers. Bear in mind that for any insurer in the small group market, about 4 percent of the covered population incurs 50 percent of the expenses. Under reform proposals, insurers would be opening their doors to the "4 percent." As a result of these additional factors, small employers that would receive a 50 percent rate increase as a direct result of community rating could in fact receive a total rate increase of nearly 100 percent.

In a voluntary market, we believe rate increases of this magnitude could increase the number of uninsured small employers, as small employers decided to drop the more expensive coverage. For these reasons, we support the rating provisions in S. 1872, with the modifications we suggested. We believe these provisions, while not going as far as some Members would like, would benefit small employers significantly. Premium rates would be much more stable and predictable, and the use of a small employer's own claims experience or health status in setting its rate would be limited. While these reforms would raise rates for some small employers—because of the coverage of higher-risk small employers and the compression of rates—we believe that the small employer market could tolerate these rate increases without encouraging more small employers to drop their current coverage because of high rate increases.

**Regulatory Framework.** We also believe that additional flexibility is needed in the regulatory structure of the bill. The Federal guidelines established in the bill would be developed into specific standards by the NAIC, which States then would adopt. We believe States need additional flexibility to modify the NAIC standards to address specific State concerns. This flexibility is needed because none of the NAIC model approaches have been proven, and they are not mature enough to be frozen into Federal law. The States that already have enacted the NAIC model laws have found it necessary to make substantial changes in the models prior to enactment. The newness and complexity of some of these models necessitate giving States the ability to make appropriate adjustments.

**Group Size.** In addition, we believe the provisions in the bill should be restricted to employers with 3–25 employees, rather than the broader range of 2–50 included in the bill. Most of the problems with availability of insurance arise in the under-25 market.

We emphasize that we would not object to application of the guaranteed availability, guaranteed renewal and continuation of coverage requirements to employers over size 25, so long as carriers were required to manage the full risk of these groups. We do not, in other words, support extending reinsurance to larger groups. As noted earlier, carriers already accept the vast majority of larger groups and manage the costs of these groups internally. There is thus no reason to spread the costs of covering these groups across the market.

We do, however, oppose applying the rating requirements to these larger groups, and the resultant pooling of the costs of these groups with the costs of groups below

size 25. While such pooling would lower the rates somewhat for smaller groups, it would increase the rates for larger groups.

On the lower end, we recommend against including groups size 1 and 2 in small group reform proposals because groups of this size are especially likely to purchase coverage only when they need It. As a result, they are much more likely to be higher-cost than average because those individuals and small groups that have health problems are much more likely to seek coverage than healthy individuals or groups, who do not feel the need to obtain coverage. Because of this adverse selection, inclusion of these higher-risk, higher-cost individuals in the small group market reforms would increase overall costs in the small group market. This is especially true in a voluntary market, where healthy smaller groups and individuals can choose to remain without coverage.

**Scope.** With respect to the scope of the bill, we are concerned that the bill may exclude certain self-funded insurance plans from its requirements, including Multiple Employer Welfare Arrangements (MEWAs). We believe strongly that any insurance market reform must include all entities providing or financing coverage to small employers, whether insured or self-funded. Exclusion of any market players would lead to imbalances in the market and provide incentives for the market to move toward such unregulated entitles, thereby undermining the very purpose of the reforms. We believe the current legislative language excludes self-funded Multiple Employer Welfare Arrangements (MEWAs) from the bill. We urge that these and all other entitles in this market be included in the scope of the bill.

**Small Employer Purchasing Groups.** Finally, I would like to address the issue of encouraging the formation of small employer purchasing groups. We do not oppose the start-up grants provided for in S. 1872.

However, we do object to the preferred tax treatment and the exemption from State insurance laws provided to these groups under some proposals. The proliferation of these purchasing groups would lead to further fragmentation of risk among small employers, as small employer groups obtained coverage from an increasing number of sources. Rather than encouraging small employers to collect into a few large pools of employees that could spread the cost of health care services over many employees, these purchasing groups could result in small pools of employees that spread risk over a limited number of employees. The purchasing groups could simply replace existing insurer pools with their own, smaller pools for spreading risk.

In addition, each group would have its own marketing and claims processing demands, thus adding to the Nation's administrative cost burden.

And, these proposals would create a regulatory nightmare. Some proposals would exempt small group purchasing arrangements from State insurance laws but do not propose a strong regulatory network for these new entities. It appears that most of the regulatory burden could fall to the Department of Labor, which lacks the funds, staff and expertise for such a massive undertaking. It is doubtful that even State governments would have adequate resources for assuring the appropriate functioning of thousands of these new arrangements.

While demonstrations to test the value of these purchasing arrangements would be helpful, we believe strongly that they should not be given a competitive advantage in the market. In addition, appropriate regulation of these entities must be assured. Such regulation will be especially important if Federal small group market reform legislation is enacted.

### CONCLUSION

In conclusion, we share the Committee's concerns about the cost and availability of insurance coverage for small employers. We understand that reforming the small employer market place will not solve the health care access problem on its own. However, these reforms will provide necessary protections for small employers, and we believe they are a good first step on our journey to securing access to coverage for all Americans. We believe this larger effort can be based on an expanded and reformed private insurance market, in partnership with the public sector.

Thank you for the opportunity to present our views today.

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## Prepared Statement of Earl R. Pomeroy

Mr. Chairman and Members of the Committee, thank you for this opportunity to discuss the important topic of health insurance reform.

I am Earl R. Pomeroy and I am the Insurance Commissioner for the State of North Dakota. I am here today representing the National Association of Insurance Commissioners ("NAIC"), which is a nonprofit association whose members are the

insurance officials of each State, the District of Columbia, and four U.S. Territories. I have previously served as President of this organization.

Perhaps the most important public policy issue for State and Federal officials is the tragic fact that over 34 million men, women and children have no health insurance and therefore have severely limited access to health care itself. The core problem underlying this tragedy is the seemingly intractable issue of soaring health care costs. The rapid, unrelenting increases in health care costs are placing a tremendous strain on the health care financing and delivery systems in this country, both public and private.

Although rising costs are the chief barrier to access, it is clear that rating and underwriting practices in the health insurance marketplace also are contributing to the access problems of many Americans. Insurers have become increasingly selective about who they will insure and on what terms the insurance may continue. These problems have caused State and Federal policymakers, including members of this Committee, to look more closely at insurer rating and underwriting practices and their effects on consumers. Our testimony will describe recent activities by the NAIC to improve the availability and fairness of health insurance for small businesses. We also will comment on some of the proposals being made at the Federal level to improve the health insurance marketplace.

## THE NEED FOR REFORM

The need for health insurance market reform is clear. Competition among insurers has become focused toward risk selection and aggressive rating practices and away from the efficient management of health care services. Although these practices permit many small businesses to get coverage at favorable rates, those with poorer health or claims history are forced to pay substantially more for coverage. Even those small businesses with relatively low rates face the prospect of large premium increases, or the potential loss of coverage, if claims experience worsens or if a worker develops a serious illness. Some small businesses and individuals cannot get coverage at all because of current or prior health problems.

For the past 2 years, the NAIC has worked with representatives of small businesses, consumers and insurers to address these problems through model legislation. In December, 1990, the NAIC adopted a model law to address rating abuses and renewability problems in the small group market. In December, 1991, we adopted a more comprehensive package of reforms that: (1) strengthens the restrictions on rating and renewal practices contained in our prior model law; (2) prohibits insurers from denying coverage to small businesses, regardless of their employees' health status or claims experience; and (3) improves portability and continuity of coverage. These model laws are briefly outlined below.

I would note that adoption of these model acts in no way signifies that State regulators have finished with their efforts to address problems in this marketplace. The NAIC views these models as a first step toward reform. Our goal was to address identified abuses without causing significant disruption to the market. The improvements we are making in rating fairness and coverage availability, unfortunately, will mean that those small businesses getting the lowest rates will have to pay more so that those disadvantaged by the current system can have access to coverage at relatively reasonable prices. In our models, we tried to balance the goals of access and fairness for disadvantaged groups against the specter of higher costs for the majority of small businesses who benefit (at least in the short run) under current market conditions. This is a terrible dilemma, made increasingly difficult by annual increases in the underlying costs of health care and health insurance that significantly outpace inflation.

Nonetheless, meaningful market reforms must be enacted if private insurance coverage is to continue to play a significant role in health care financing. Not only are reforms necessary to assure availability and improve equity in the marketplace, but elimination of excessive risk selection is essential if managed care is to succeed as a significant cost containment strategy, especially in the small employer and individual health insurance markets. Insurers competing on risk selection have little incentive to manage risks efficiently—it is far easier to raise premiums for poorer risks and force them to go elsewhere for coverage. Meaningful reforms can reduce these ill effects of excessive risk selection. State regulators are committed to continuing along the path of market reform, toward a more stable marketplace based on principles of broader pooling of risk and efficient management of care.

*Rating and Renewability Practices*

Premiums for small group health insurance have been determined, for the most part, through competition. In recent years, insurers have begun competing for business by offering low rates in early years and "building in" rate increases if the group continues with the insurer. This is called "durational rating." Low initial rates are possible because insurers medically underwrite (use health screening) to assure that the group is healthy before they accept it for coverage. A healthy group will generally produce lower than average claims experience, so the insurer can charge lower rates initially. However, the benefit of health underwriting "wears off" after 2 or 3 years (some employees will become sick or have accidents), requiring the insurer to raise rates to fund the predictable increase in claims.

Insurers also have begun introducing experience rating in the small group market. Because initial rates are low, insurers, on average, need to raise rates for groups that continue with the insurer. However, if the insurer builds in rate increases for all groups, the healthier groups (who can pass medical underwriting with another insurer) will move to another insurer to keep a low initial rate. In response, insurers have developed "tier rating." In tier rating, the claims experience of a group is used to select its premium level at renewal. Insurers increase rates more for groups with poor claims experience (e.g., high claims frequency, employees with serious or expensive illnesses). In some cases these rate increases have been extremely high.

In many cases, insurers also can choose not to renew coverage for a group. For example, an insurer may choose not to renew a group's coverage because the group has poor claims experience or because an employee or dependent has developed a serious medical problem or disability. Or, in cases of multiple employer trusts, insurers may nonrenew or terminate the master policy because claims for the arrangement are beyond those anticipated. Small employers that are not renewed may have a hard time finding replacement coverage because they will be unable to meet insurer medical underwriting standards.

In response to these problems, the NAIC has adopted model legislation aimed at rating and renewal practices in this marketplace. The NAIC provisions: (1) place limits on certain rating practices and require actuarial certification of rating methods; (2) limit significantly an insurer's ability not to renew a group's coverage; and (3) require increased disclosure to consumers of insurer rating methods.

The rating restrictions developed by the NAIC provide that: (1) within any class [1] of small group business, rates for similar groups for similar coverage can vary by no more than 25 percent around the midpoint; (2) for all classes of business, the midpoint rate of any class may not be more than 20 percent higher than the lowest-rated class of business; and (3) in any year, the maximum increase that an employer may receive would be equal to the change in the rate for new business in that class plus 15 percent. A change in the number or make-up of employees also could affect the employer's rate at renewal.[2]

The NAIC provisions also require each insurer to keep on file for examination a detailed description (including documentation) of the insurer's rating methodology and underwriting practices. In addition, each insurer must file an annual actuarial certification that the insurer's rating methods comply with the new standards and are based on sound actuarial principles. These requirements will improve the ability of insurance regulators to monitor the rating practices of insurers and enforce the limits on rating practices described above.

In addition to the rating provisions, the NAIC provisions significantly limit the ability of insurers to nonrenew coverage by: (1) generally prohibiting nonrenewal by the insurer of individuals or dependents within a group; (2) generally prohibiting the nonrenewal by the insurer of groups within a class of business; and (3) permitting nonrenewal of a group only if an insurer chooses not to renew all of its small group business in State.[3] An insurer that does not renew its small group business

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[1] Insurers use separate "classes" or "blocks" of business to distinguish different groups of business that should produce different results. Different classes include business that is insured through or for a bona fide association, business marketed through a different method of distribution (e.g., agent sold or direct marketed), and a class acquired from another carrier. The NAIC provisions limit the number of classes an insurer may have to nine.

[2] Essentially, in any year, the maximum change in rate that could be attributable to a group's health status, claims experience or duration of coverage is 15 percent. Otherwise, the annual rate change is based primarily on the change in rate for new business—which should reflect the trend in health care costs and utilization.

[3] Nonrenewal is permitted in cases of fraud, failure to abide by provisions of the contract, or if the small employer is no longer engaged in business.

in a State is prohibited from offering coverage to new small businesses in that State for a period of 5 years.

Finally, the NAIC provisions require insurers to disclose the following information at the time of purchase: the insurer's right to change rates; any factors, including the group's claims experience, health status, or duration of coverage, that could affect the group's rate; the class of business the group would be placed into; and the conditions that affect renewability of coverage. Disclosure of these factors will enable small businesses to make more informed purchases of group coverage and to better understand how their rates may change at renewal.

*Improving Availability of Coverage*

The NAIC also has developed model provisions to improve availability of health insurance coverage for all small groups. Currently, in order to protect themselves against adverse selection,[4] insurers medically underwrite small groups before accepting them. Groups that have sick or disabled employees or dependents often find it extremely difficult, if not impossible, to get health insurance. Sometimes these groups deliberately exclude the sick individual from the group plan in order to obtain coverage for the remainder of the group. In addition, some insurers refuse to write coverage for groups in certain professions or occupations that they consider higher risk.

To address these problems of availability, the NAIC has developed two alternative approaches to assuring that all small employers have access to health insurance coverage without regard to the health status or claims experience of the group or its workers. One approach is based on a "reinsurance concept"[5] developed first in the State of Connecticut; the other is based on the "assigned risk concept"[6] prevalent in property and casualty insurance.

As part of these efforts to assure availability, the NAIC models also contain provisions to improve the portability and continuity of coverage. These provisions require insurers to insure all eligible employees and dependents of a group and prohibit insurers from assessing new waiting periods for preexisting conditions when groups change carriers or when insured individuals change employers. These provisions protect against lapses in coverage or denial of coverage to certain group members because of their health status. They also address the problem of "job-lock" by prohibiting preexisting condition exclusions when insured individuals change jobs.[7]

*Future Efforts*

As mentioned above, the NAIC views these reform efforts as initial steps and we will continue our efforts to improve the fairness and efficiency of the marketplace. Currently, an NAIC working group is designing significant reforms to address abusive rating practices that are beginning to surface in the individual health insurance market. Another working group is exploring the development of model legislative provisions to encourage the formation and operation of small employer purchasing groups. And we will be reviewing the recently enacted small group reforms to determine if changes or additional standards are needed. We plan to work closely with representatives of small businesses and individual consumers to assure that our efforts fit consumer needs at costs that can be borne within the marketplace.

## STATE LEGISLATIVE ACTIVITY

The issues of health insurance market reform and access to health care have been widely considered in recent State legislative sessions. States have been active in adopting legislation to improve access to health care, including providing tax incentives to small business and modifying or eliminating benefit mandates in the small employer marketplace. Well over one-half of the States have considered health insurance reforms, and at least fourteen States already have adopted legislation to ad-

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[4] Adverse selection is the tendency of individuals with higher risk of loss to preferentially seek coverage.

[5] Under a reinsurance approach, insurers can choose to reinsure high-risk individuals or groups (under set rules and premiums) with the reinsurance pool. The group will be charged a premium that is somewhat higher than average, but in most cases substantially lower than the premium needed to cover the group's losses. The extra costs are spread throughout the market through the reinsurance pool.

[6] Under an assigned risk approach, insurers would be required to accept a certain percentage of high risk groups, based on their share of the small group health insurance market.

[7] The NAIC provisions require small group insurers to give credit to new enrollees for any previous coverage—even coverage from self-funded plans—that contained at least basic health insurance benefits. We must note that, because of the Employee Retirement Income Security Act, or ERISA, State regulators cannot require self-funded health plans to provide similar protections.

dress rating and renewability of coverage issues. At least four States have adopted comprehensive reform legislation—including provisions to assure coverage availability—with at least a dozen more considering such legislation at the present time. The NAIC staff has answered numerous questions from State legislative and regulatory offices about its initiatives, and we expect many more States to consider and adopt insurance reforms within the near future.

FEDERAL LEGISLATIVE PROPOSALS

Although the NAIC has no position on the need for a Federal role in health insurance reform, we are pleased that S. 1872, introduced by Chairman Bentsen, as well as most of the other health insurance bills introduced by members of the Finance Committee, recognize the important roles that States and State regulators can play in achieving meaningful reforms in the health insurance market.

Insurance has traditionally been regulated by States, and State regulators have the experience and expertise to develop and implement needed reforms, whether dictated at the Federal or State level. State regulators also are more proximate to the problems that arise with insurance. Health insurance, whether written by a nationwide trust or a local health maintenance organization, is a local problem that can dramatically affect individual consumers and employers. Experience has demonstrated that State regulators, by the nature of their location and mission, are more responsive to the needs of individual consumers than Federal agencies, who are forced to focus on relatively large problems with national implications.

Further, State implementation of market reforms can provide needed flexibility and promote valuable innovation. Flexibility is needed because State marketplaces differ dramatically—in some markets, where aggressive rating and underwriting has not taken hold, a rapid move to tighten rating constraints, or even community rating, may cause little market disruption. In other States, now plagued by aggressive insurer underwriting and rating practices, a longer transition may be needed. Innovation is needed because these reforms are new, especially the reinsurance and allocation concepts developed by the NAIC and recognized in S. 1872 and other major reform proposals. We will need State experimentation and innovation to identify the best and worst aspects of the proposals.

Our advocacy for flexibility and innovation, however, should in no way be seen as an attempt to stall or delay reform. Dramatic changes in insurer underwriting and rating practices must be implemented as soon as possible. The bills before the Finance Committee, like the NAIC model acts, call for reforms in the areas of insurer rating and renewability practices, guaranteed availability of coverage, and portability of coverage. While there are some variations in approach, the differences are minor relative to the broad agreement on the need for action in each of these vital areas. The NAIC pledges to work with this Committee and with other interested parties to achieve these needed reforms and to produce a fairer and more accessible health insurance marketplace.

There are provisions of several proposals at the Federal level, however, that cause concern for State regulators. Several proposals have suggested preemption of State premium taxes for certain small employer group purchasing arrangements. As mentioned above, there is active interest among States and by the NAIC in exploring the potential benefits of group purchasing for small employers. We urge caution, however, against diminishing State revenues at a time when increased oversight of the health insurance marketplace is needed. We support provisions in S. 1872 that would provide funding for States to experiment with group purchasing arrangements as a way of improving affordability for small employers.

We also are concerned by proposals to expand the ERISA[8] preemption of State regulation for certain small employer arrangements. State experience with multiple employer arrangements that have attempted to operate under ERISA has been very poor—with numerous insolvencies and many unpaid claims. Further, the Department of Labor has neither the experience nor the staff to adequately regulate small employer insurance arrangements. The NAIC believes that expansion of ERISA would lead to further fragmentation of the small employer health insurance marketplace and fewer protections for small employers. While ostensibly a pension reform act, ERISA also preempts virtually all State insurance laws as they relate to the health benefit plans of most large employers and collectively-bargained multiple-employer arrangements. ERISA preempts all State regulations for self-funding employers.[9] ERISA expansion should be viewed with the greatest of caution.

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[8] Employee Retirement Income Security Act of 1974.

[9] State insurance laws which are preempted include those addressing: unfair trade and claims practices; adequate notice to applicants and insureds; insurance rating, renewability and con-

Indeed, many informed policymakers, including State regulators, would argue that the ERISA preemption of State laws should be narrowed rather than expanded. The ERISA preemption fundamentally segmented the insurance marketplace and has greatly inhibited States in their ability to design and implement effective market-based reforms. The basis of market reform is broader pooling—increasing the base over which risk is spread to avoid focusing higher costs on a narrow segment of the pool. ERISA impedes market reform by limiting the base over which States can design fair and equitable pooling and by permitting the most stable and economically viable insurance arrangements to avoid any costs but their own. Thus, the costs of market reforms must be borne solely by smaller groups and individuals—the most vulnerable segments in the marketplace. For example, the inability to collect assessments from self-funded plans has substantially impeded the efforts of States to develop effective health risk pools for uninsurable individuals. The NAIC believes that States should have the authority to include all health insurance arrangements, including those that self-fund, in their reform efforts.

CONCLUSION

The NAIC appreciates the opportunity to discuss the issue of access to health insurance. As insurance regulators, we feel that our role is to regulate the insurance marketplace so that it operates fairly and efficiently to provide coverage to the broadest possible group of individuals. The NAIC hopes that its market reforms will produce an insurance market that is fairer, more accessible, easier to understand, and more predictable. We all must recognize, however, that most of the uninsured do not have coverage because they or their employers cannot afford it. Health insurance market reform must be accompanied by meaningful cost containment if we are truly to improve access to health care and health insurance. The NAIC pledges to work cooperatively with this Committee and other Federal and State officials as we search for ways to contain health care costs and improve insurer rating and underwriting practices.

RESPONSES OF MR. POMEROY TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

*Question No. 1.* According to an analysis done by the Congressional Research Service, premiums of a local carrier in the metro area vary as widely as 2 to 1 based on geography—downtown D.C. premiums are twice those in Frederick County, MD—and by almost 2 to 1 in addition for industry.

Combining the impact of all these "demographic" rate adjustments, the least favorable small group could be *charged over 10 times more* than the cheapest group.

Again these are the extremes. But the purpose of insurance is to pool the extremes so that, on average, no particular person or small group has to pay extremely high costs.

A 10-fold mark up could crush an individual small business. Certainly it could discourage the purchase of coverage. Why should we permit this kind of unlimited variation, based on demographic characteristics alone, to persist?

*Answer.* As you know, rating factors are used to assign the costs of coverage to those who present a higher risk of loss. These adjustment clearly can have a significant impact on the ability of some groups to afford coverage. I think most people, myself included, would like to move toward a rating system with far less variation than what we see today. Unfortunately, the current system allows massive variation in rates, based both on demographic characteristics and on claims experience, and reducing these variations has the potential to cause significant dislocation in the marketplace.

As I Stated in my testimony, the current system of experience rating has, in the short run, many winners to balance against fewer losers. Moving to correct this imbalance will produce rate increases for many insured individuals. It may prove difficult to compress rate variation caused by demographic adjustments at the same time you phase out experience rating—some groups could take a "double" hit that may affect their ability or desire to insure at all. One also must consider the percentage of the current uninsured who are young—moving too quickly to demographic rate compression without some subsidy mechanism could actually be moving them away from becoming insured.

How broadly risk should be pooled is clearly an important public policy issue. If Congress is going to legislate in this area, it must consider carefully how risk is shared and what groups are going to be required to provide subsidies to other groups. In addition to the issues presented by demographic and experience rating

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tinuity of coverage provisions; guarantee fund and insolvency protection; and coverage requirements.

adjustments, other important issues, such as pooling across market segments, must also be addressed. Why, for example, if Congress is interested in broad-based pooling, should larger groups be permitted to segregate their experience from the insured market. Such segregation not only deprives insurance pools of large blocks of stable risks, but also decreases the ability of insurers to negotiate favorable rates with providers.

*Question No. 2.* The NAIC permits renewal rates to be increased by 15 percent based solely on a group's claims experience or change in health status. Once again returning to the concept that insurance is meant to pool risk, how do you justify a 15 percent increase—over and above inflation—because one person or several individuals in a small group had the misfortune of getting sick or being seriously injured?

*Answer.* The 15 percent yearly increase permitted by the NAIC to reflect differences in experience, health status or duration was intended to stop the large premium increases—sometimes more than 100 percent—experienced by poorer risk groups in the current marketplace. The NAIC is sensitive to the concerns of those who want to further reduce the influence of claims experience and health status on insurer rating practices. AS I stated in my testimony, the NAIC views its model bills as a first step toward market reform. We will continue to monitor and evaluate the rating bands we have put in place in light of their effects on affordabilty and overall fairness.

*Question No. 3.* There is some evidence that insurance companies are medically underwriting groups as large as 100.

I was *extremely* pleased that the President defined small group as under *100* employees in his recent health reform proposal. The NAIC small group reforms only apply to small groups with no more than 25 employees. What was your rationale in limiting your reforms to under 25?

What happens to the small employer market if discriminatory pricing is permitted to persist for groups above 25 or 50?

*Answer.* The NAIC limited the effect of its reforms to groups of 25 or fewer because we felt that this was the segment of the market primarily affected by discriminatory pricing and exclusionary practices. However, the NAIC model contains a drafting note to States suggesting that a different threshold may be appropriate, depending on the underwriting and marketing practices in the State.

In addition, as I suggested at the hearing, raising the group size above 50 employees leaves open the potential that some groups may try to escape the new standards by self-funding under ERISA. AS long as the ERISA loophole exists, States will be constrained in designing the ideal health care and health insurance reforms.

*Question No. 4.* As you have noted in your testimony, more than one half of the States have recently considered health insurance reforms. Many of them, in an attempt to make insurance more affordable to small employers have adopted so called "bare bones" insurance policies. Most of these policies would not provide any real financial protection in the case of a catastrophic illness or injury.

In fact, the President's health reform proposal would require States to design benefit plans that could be bought for $3,750—the amount of the tax credit he has proposed for those under poverty to help them buy health insurance. The President's white paper provides some examples of policies that could be bought at that price. All of the policies outlined, except for a HMO policy, did not provide comprehensive health coverage. For example, one benefit plan would cover unlimited hospital stays but only 3 doctor visits a year. Another benefit plan illustrated would cover unlimited doctor visits, but only cover 15 inpatient hospital days a year.

Is this really the way to make insurance more affordable? By cutting back on benefits?

*Answer.* The NAIC proposal calls for States to make both a standard benefit plan and a basic benefit plan available to all small employers. These benefit plans would be designed by committees appointed by the Governor and representing employers, employees, providers, insurers and producers. We hope that the broad representation on these committees will ensure that the plans are designed to balance meaningful benefits with premium affordability. However, it must be recognized that designing affordable benefit plans becomes increasingly more difficult because of society's inability to control underlying health care costs.

*Question No. 5.* Clearly, any insurance reforms that attempt to significantly narrow current insurance rating practices will need to be phased-in over time to avoid major disruption and dislocation in the insurance market. The President's plan proposes a return to "flexible" community rating after a 5-year transition. While I admit I am not sure what he exactly means by "flexible," I am an optimist by nature and so encouraged.

In your opinion, what would be a reasonable length of transition from our existing discriminatory premium structure to a community-rated health insurance system?

*Answer.* The NAIC has not studied the amount of time it would take to eliminate both experience and demographic rating from the small group market without causing severe disruption and dislocation. As I understand it, the term "flexible community rate" in the President's proposal is intended to address only experience rating. Given the tremendous price variation that now exits, couple with the extreme price sensitivity of small employers, I personally feel that the 5 years identified by President Bush would be a minimum time for complete elimination of experience rating in this marketplace. It may take somewhat longer to phase in a pure community rate.

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PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, we have a large and impressive collection of witnesses today, so I will not spend a great deal of your valuable time on an opening statement. I would like, however, to commend you on holding a hearing on S. 1872, a bill that makes important first steps toward reforming our terminally ill health care system.

I would also ask unanimous consent to insert in todays' hearing record a copy of the statement I made when I joined you in introducing S. 1872 last October. This statement outlines the many reasons why I cosponsored your bill and details some of my thoughts about the intimidating health care challenge that confronts this Nation.

In closing, Mr. Chairman, I want to highlight just a few issues that illustrate how the small businesses of our Nation have been singled out to get the absolute worst treatment from our Government and our health care system in general. These and many other problems were outlined in a series of field hearings I held last week in Arkansas:

(1) *Tax Policy Discrimination.* Today, while Donald Trump and General Motors receive a 100 percent deduction for their health care costs, self-employed small businesses only get a 25 percent deduction. As a result, these businesses are not only discriminated against by insurers charging higher premiums for the same policies, but they are victimized by our inequitable tax code.

(2) *Insurance Industry Underwriting Discrimination.* Large businesses are not being victimized by aggressive medical underwriting by insurers. Many small businesses are being targetted to the point that they either are completely denied coverage at any price or being charged unaffordable prices.

(3) *Job Lock.* As a result of insurance underwriting practices, too many employers and employees are so afraid of losing health insurance that they turn down great job opportunities just to assure that they don't lose coverage for themselves or their families.

(4) *Disproportionate cost shifting.* Though rarely acknowledged, small businesses are the group that is suffering most from skyrocketing health care costs and government's and big businesses' reaction to these costs. Low Medicaid reimbursements are cost shifted to the private sector. Then, managed care plans run by big businesses shift their added costs to small businesses.

Chairman Bentsen, to your credit, your bill addresses each and every one of these issues. As you would be the first to acknowledge, there is more to be done. I think we must be willing to do more on the cost containment side of the equation. As you well know, I have and will continue to exhibit my willingness to confront the drug manufacturers and their exhorbitant pricing practices.

Having said this, I believe you should be commended for the significant achievements of your bill. I look forward to working with you, other members of the Finance Committee, Senator Bumpers, and others in developing desperately needed solutions to the health care crisis this Nation faces.

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## Senate

Mr. PRYOR. Mr. President, today I am pleased to join the esteemed chairman of the Finance Committee, Senator LLOYD BENTSEN, in introducing the Better Access to Affordable Health Care Act of 1991. In introducing this legislation, Chairman BENTSEN once again demonstrates his deep concern about, and commitment to, addressing the health care crisis that this Nation faces.

Before commenting on the specifics of the bill and the reasons for my cosponsorship, I believe it is also important to recognize the leadership of a number of our colleagues in the health care arena. No list of health leaders would be complete without the majority leader, Senator GEORGE MITCHELL. Despite the overwhelming demands on his time, Senator MITCHELL has not hesitated to roll up his sleeves and take on the extraordinarily difficult challenge of health care reform.

Like the majority leader, Senator JAY ROCKEFELLER—the former chairman of the Pepper Commission and current chairman of the Finance Subcommittee on Medicare and Long-Term Care—is a man whose commitment to solving our intimidating health care problems is unsurpassed. As a member of the Pepper Commission, I not only had the honor of serving under Senator ROCKEFELLER, but I also had the privilege of working with three other giants in the health care debate: Senator KENNEDY, Senator DURENBERGER and the late Senator JOHN HEINZ. Senator RIEGLE must be singled out as well for his tremendous leadership as chairman of the Finance Subcommittee on Health for Families and the Uninsured, and as one of the driving forces behind the introduction of S. 1227, Health America: Affordable Health Care for All Americans.

Mr. President, jumping into the health care debate is like diving into the ocean for your first swim. You are leery of the water's temperature, worried about the threatening waves, and afraid of the unknown creatures and dangerous undercurrent lurking below. It is for this reason that I believe my colleagues who I have previously mentioned, as well as Senators BAUCUS, DASCHLE, KERREY, METZENBAUM, SIMON, and others who have made health care reform a high priority, deserve great praise and commendation for having the courage and the caring to move this debate forward.

Mr. President, no one disputes the fact that our health care system is chronically, if not terminally, ill. We are all starting to memorialize the intimidating statistics. There is no other Nation in the world that spends as much of its gross national product on health care as the United States. And, despite these fact we are well on our way to spending $1 trillion a year—almost $700 billion this year—on health care, 33 million Americans—and 20 percent of all Arkansans—live without health insurance.

While our unprecedented investment in dollars provides is with arguably the highest quality and most technologically advanced health care in the world, the only people who have access to this care are those who can afford insurance to pay for it. If costs keep soaring as they have been, spending on health care will increase from $662 billion in 1990 to an almost unbelievable $1.6 trillion by the turn of the century. During the same period of time, the percentage of our gross national product allocated to health care will increase from 12 percent to a staggering 16.4 percent. As a result, we have every reason to believe and fear that fewer and fewer people will be able to afford the health care and insurance protection they need.

Insurance companies, responding to these costs and attempting to limit their liability, have turned more and more to underwriting and marketing practices that discriminate against small businesses and individuals. As a result, individuals and small businesses seeking coverage are priced out of the market or sometimes excluded at any price. Denial of coverage is even a problem for people who have had insurance for years and are simply changing jobs. These are just two examples of how flawed our health care system has become.

I often say that the Federal Government waits until it has a crisis on its hands before responding to difficult issues. The day has finally come when everyone—individuals and their families, consumer advocates, small and large businesses, unions, health care providers, and insurers—agrees that our health care system has reached that crisis stage. Unfortunately, while we have universal agreement that we must reform the system, there is no such agreement on how to proceed.

Mr. President, the lack of consensus and the fact that it will be extraordinarily difficult to reform the health care system is not excuse for not trying. While it has become clear that the widely varying approaches and interests will make it impossible to overhaul the system this year, we can take important incremental steps toward that goal if we make progress on those issues in which there appears to be the most agreement. The Better Access to Affordable Health Care Act of 1991 does just that.

When I served on the Pepper Commission, Republican and Democratic Members alike seemed to agree that we should reform the small business insurance market, provide insurance portability protections for persons changing jobs, develop minimum benefit plans designated to preempt State mandates, increase the tax deduction for the self-employed from 25 to 100 percent, protect true managed care initiatives from antimanaged care laws, and provide more preventive health care services. The legislation we are introducing today incorporates provisions that address all of these priority items. Moreover, by establishing a health care cost commission, the Better Access to Affordable Health Care Act begins to address the issue driving the health care reform debate—finding ways to contain health care costs. Taken in combination, Chairmam BENTSEN's proposed reforms are significant, meaningful, and more than worthy of serious consideration.

Despite these important provisions, the legislation we are introducing today is not perfect. Senator BENTSEN would be the first to acknowledge this. I am particularly concerned about the adequacy of its small business insurance reforms, its improved but still limited protections for the self-employed, the appropriateness of its managed care definition and protections, and its lack of more meaningful cost containment provisions. And, in my capacity as chairman of the Special Committee on Aging, I believe that we should give serious consideration to incorporating private long-term care insurance consumer protections in any package of insurance market reforms.

Further, within the context of these incremental reform efforts, I believe we can take additional important steps toward containing health care costs and, as a result, expanding access. We could reduce billions of dollars a year alone in unnecessary spending if we could develop more effective ways to address the fraud and abuse that is all too prevalent in our health care industry. We could save billions more if we could get a handle on overly burdensome and duplicative paperwork requirements. Further, where we are overpaying health care providers, suppliers and manufacturers—and in some cases underpaying others—we must take actions to develop more rational reimbursement systems. As many of my colleagues know, I have already exhibited my willingness to confront the prescription drug manufacturing industry in this area. And, where there are other abuses, I do not believe we should hesitate to take on other health care industry representatives as well.

Having said this, I am cosponsoring this legislation because I know that Chairman BENTSEN is more than open to suggestions to strengthen this bill. In fact, by introducing this legislation, he is explicitly soliciting comments. Like Senator BENTSEN, I am looking forward to receiving advice from all interested parties inside and outside the Washington, DC, beltway. It is clear we could benefit from new ideas.

Mr. President, in supporting this legislation, no one is sending the message that we have given up on comprehensive reform. I have simply concluded that taking some steps forward is preferable to taking no steps at all.

The Better Access to Affordable Health Care Act provides us with a solid foundation onto which we can build. We owe a debt of gratitude to Chairman BENTSEN for developing this legislation and giving a needed shot in the arm to the health care reform debate.

It is my sincere hope that President Bush will take the bill we are introducing today, as well as any other health care reform initiatives that have been or will be introduced, as an invitation to join us in responding to the health care crisis confronting this Nation. America is waiting for and demanding his and our leadership in this area. In that spirit, I urge all of my colleagues to join Senator BENTSEN and those of us cosponsoring this legislation in this challenging but essential undertaking.

## Prepared Statement of Senator John D. Rockefeller IV

Thank you, Chairman Bentsen, for holding this hearing today on reforming the small group insurance market. As an original cosponsor of your legislation, S. 1872, and the author of comprehensive health reform legislation that includes small group insurance reforms, I am eager to join you and the Committee in delving into this very important issue.

It has been a little more than a year since the Pepper Commission concluded its deliberations and released its recommendations on comprehensive health care reform and long term care. A key element of our health care plan is reform of the small group insurance market. In fact, the final vote of 8–7 on that plan completely masked the unanimous support within the Commission, expressed over and over again by all 15 members, for reforming the small group market.

Prior to the release of the Pepper Commission recommendations, reform of the small group insurance market, along the lines proposed in our bills, seemed unthinkable. Now small group insurance reform is viewed as the "easy" part of reforming our health care system. One of the obvious reasons is that it represents action we can take without costing the Federal Treasury. But the more serious reason is that the market has deteriorated so badly, so fast, that even the insurance companies realize that government intervention is needed to clean up the market and "level the playing field."

I commend the HIAA and Blue Cross/Blue Shield for developing their own proposals on reforming the small group market. Their reforms are starting points, but I am afraid that they do not go far enough.

While some of the reforms proposed—guaranteed issue, guaranteed renewability, and especially the rating reforms—may actually increase insurance rates for some groups, today *every* small business owner lives in fear that a serious illness or injury of one of his employees or a family member will send his or her insurance rates through the roof. It's time to restore predictability and stability to the private health insurance market.

Over the last few months, at town meetings in West Virginia and at Congressional hearings held across the country, I have heard countless stories of small business owners struggling to pay for health insurance for their workers. After facing massive premium hikes year after year, many of them have been forced to drop or severely restrict their coverage. Even many who thought they had adequate insurance, found out their coverage was grossly insufficient when they needed medical care—even for something seemingly as simple as a broken thumb. And, millions of Americans are staying in dead-end jobs for fear that changing a job means loss of health benefits.

The comprehensive health reform bill that I have introduced along with the Majority Leader, Senator Mitchell, and Senator Riegle, builds on, but would substantially reform, our health care system. Reform of the small group market lays the foundation for building on the current system. But if the reforms are not effective and only half-hearted, we will be building our foundation on quicksand and the entire system will collapse.

While earlier I said that small group insurance reform was viewed as one of the "easier" aspects of reforming our system, many of the policy and technical issues involved in small group reform are far from easy. But I think common sense can guide us, if we remember what insurance is all about—sharing risk. We should work toward reforms that will no longer financially penalize—through higher health insurance premiums—young women, older men, those unlucky enough to be in poor health, workers engaged in risky occupations, or families who live in an undesirable part of town. It's time to put an end to abusive insurance practices that have already cost millions of Americans their peace of mind, their homes, and their very livelihood.

Thank you.

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## Prepared Statement of Ree Sailors

### AN OVERVIEW OF THE PROGRAM

The Florida Health Access Corporation is a private non-profit corporation created pursuant to State legislation passed in 1987. The Corporation is charged with the mission of finding ways to make health coverage more affordable and accessible for small uninsured businesses and their employees and dependents. Florida Health Access began as a joint venture between the State of Florida, Hillsborough County (Tampa) and the Robert Wood Johnson Foundation. The program serves businesses which have fewer than twenty (20) employees. It currently is available in sixteen

(16 of 67) counties and serves over 2300 previously uninsured small businesses and over 10,000 workers and dependents.

The strategies employed by Florida Health Access are predicated on several observations:

Instituting the benefit within the business is a very significant decision on the part of the owner/business;

Most small employers want to provide the benefit but cannot afford it and don't have a lot of time to devote to negotiating;

The small group market for health coverage is not accustomed to organized buying, and not always receptive to it.

Once in the market of health coverage, small businesses cannot absorb "rate shock," or significant premium increases.

Both employers and employees are willing to contribute toward the cost of health coverage.

Florida Health Access organizes small businesses into an organized buying power. This organization has enabled small businesses to access HMO health plans which were not previously available to small businesses. HMOs typically did not market to small businesses because of the high cost of administration and marketing associated with servicing many, many tiny businesses. Florida Health Access handles the "front-end" administration of the group by selling, signing-up, billing to and collecting from the individual small businesses. The cost of this front-end work is directly absorbed by the State of Florida through its contract with the Corporation for this work. This form of "indirect subsidy" reduces premium to the small employer thereby helping to reach affordability.

Florida Health Access also engages in some reinsurance to produce a further reduction in premium, and finally, we administer an across the board direct subsidy for family related rates in order in enhance the affordability of dependent coverage for workers. The combined effect of all subsidies can reduce premium by approximately 25 percent for small businesses entering the health coverage market for the first time. By definition to be eligible for the subsidy program a business must have been "uninsured" for at least the previous 6 months.

### THE EFFECTS

Since its inception, FHAC has forged a proactive partnership with the small business community. It represents an initiative by government which attempts to realistically and aggressively tackle a serious problem using sound business practices. It recognizes that the reasons for market failure in the small group market are many, varied and complex. It has created an administrative infrastructure to marshall the financial resources of private small businesses and government. It has applied those combined resources to empower the "purchaser/consumer of health care, in a way that residually creates a regional force with which the health care providers and insurers must deal.

### THE PROPOSED LEGISLATION: HOW IT WILL HELP

The "Better Access to Affordable Health Care Act" proposed by Senator Bentsen addresses many of the factors contributing to the lack of insurance among small businesses. The small group reforms are a relief to see; but I would like to focus my remarks on the provisions for grants to States for small employer health insurance purchasing programs. Obviously, this type of grant program would allow organizations like ours to be developed more fully not just in Florida, but throughout other parts of the country. I believe that this grant initiative reflects an insight into the problem and its origins not often recognized. The small business community, and especially the micro-sized business with fewer than five employees needs help organizing. It is an area where intervention is appropriate. The financial assistance offered through the grant program recognizes the reality that some form or several forms of subsidy will be necessary to engage the small business into the health coverage marketplace. Once in the marketplace, this type of enabling administrative support allows the small business community to participate fully and to eventually step into the active role of "Consumer" in a market that has been allowed to operate with impunity for its lack of economic discipline.

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PREPARED STATEMENT OF JUDITH WAXMAN

Mr. Chairman, thank you for inviting me to testify before your Committee. Families USA is a national non-profit advocacy organization devoted to working for families on health care and long term care reform.

Our health care system is in crisis due to soaring cost and decreasing insurance coverage. Today's hearing addresses a number of small business reforms, some of which may be helpful to families. But, as this Committee is very aware, these steps do not substitute for comprehensive reform. Only when costs are controlled systemwide and everyone has coverage will the crisis be brought under control.

RISING HEALTH CARE COSTS AND DECREASING INSURANCE COVERAGE

Health care costs in the United States have risen dramatically, far outpacing general inflation, as well as growth of the economy and of families' incomes. These spiraling health costs are creating an emergency—a crisis of affordability for consumers, government, labor, and business. Families are paying more in premiums, deductibles and co-payments.

In 1980, American families on average paid a total of $1,742 for health care, including out-of-pocket expenses, health insurance and State and Federal taxes that go for health programs. By the end of this decade, that same family will be paying $9,397 for health care, an increase of 439 percent.

Businesses have also been hit by rapidly rising health costs. Business payments for health insurance tripled from 1980 to 1991 and are expected to rise sevenfold between 1980 and 2000.

Rising costs have also resulted in a growing number of Americans without adequate health coverage, or none at all. One of the major reasons for the increase in the number of uninsured persons is a reduction in the number of individuals and their families covered by employment-related insurance. This is because, in recent years, there has been an increase in the number of persons employed in businesses that don't offer health insurance, or offer inadequate or unaffordable insurance. The sad fact is that the number of uninsured Americans has increased, from 24.5 million persons in 1980 to 35 million persons in 1990. Twenty-eight percent of U.S. residents, 63 million people, lacked health insurance for at least a month during the 28 month period ending May 1987, according to the Census Bureau.

Given the crisis our health care system is in, we must acknowledge that the reforms we address today will not affect the underlying causes of health care inflation—excessive increases in provider charges; proliferation of duplicative and expensive technology; and unnecessary procedures. Therefore, double digit increases in premiums will continue and small businesses will still find insurance out of reach.

SMALL GROUP INSURANCE MARKET

A crucial component of any health care reform is changing the rules by which all insurers operate. The rules that govern the issuance of private insurance need to be made standard and fair. Reform can eliminate extreme fluctuations of the premiums for private insurance and may make it more available for small businesses, preventing some businesses from losing the coverage they have now and possibly helping some small businesses obtain coverage for their employees.

However, all small businesses will not be helped. Individuals with pre-existing conditions will be added to health plans, which is a vast improvement in current practices. The downside of this reform is that premium costs will go up to cover these people which could mean that some businesses decline coverage. The only solution is to include cost containment, which is crucial to assure that insurance does not become even more out of reach for businesses the legislation intends to help.

Families USA Foundation's own experience is illustrative of the problems small businesses are having with the health insurance marketplace. Over the past 3 years, our premiums, for a group of approximately 25 employees and their families, increased 27 percent, 52 percent and 39 percent, and would have increased another 51 percent in 1991 had we stayed with the same commercial carrier. Our health insurance costs increased from 5.7 percent of payroll costs in 1988 to 12.5 percent in 1990.

We have sought coverage with numerous other carriers, but found that we had few options. Most major insurers declined to submit bids. Managed care plans were equally unwilling to cover us. There is nothing unusual about our group. Our employees are getting older—starting families and beginning to develop the health conditions that come with middle age. We have a few group members with serious health problems, but none of these are extraordinary.

After the investment of significant administrative time, we were fortunate to get coverage from another carrier at approximately the same rates as we paid last year. This is because we will be community-rated. Once this carrier has sufficient experience with our group, we will again be experience-rated and fully expect to face a significant premium increase.

The kinds of annual premium increases we have experienced wreak havoc on the budgets of small businesses. Very few can absorb such increases and few have the time or expertise to negotiate in the health insurance marketplace. As part of our efforts to find another carrier for ourselves, we surveyed similarly-sized non-profits in the Washington area. Most of these had experiences similar to ours and were eager for us to share any "solution" with them. We are in the process of analyzing surveys from a large number of non-profits so that we will have better data on the experiences other non-profits have with health insurance.

Our experience taught us that the idea of spreading risk and distributing costs broadly has completely broken down in the small group and individual (non-group) insurance markets. In a desperate effort to offer lower premiums, insurers now compete to avoid risk and to reduce benefits, rather than to spread risk and offer comprehensive coverage.

Underwriting—the process of determining at what price and under what circumstances an insurance company will assume a given risk—is at the heart of the problem. Screening individuals based on their health status, occupation, age, and gender adds to already high administrative costs. For example, insurance officials testified to the Maine Continuity of Coverage Task Force that current underwriting practices account for 15 percent of small group premiums.

The goal of insurance reform should be to eliminate medical underwriting because it not only adds to administrative costs but it excludes people from coverage and results in higher premiums for anyone with a health problem.

*Continuity and Availability of Coverage*

We appreciate your interest and concern, Mr. Chairman, on the issue of portability of coverage. S. 1872 offers significant protections against certain underwriting practices for some employee groups who opt to buy the "standard" or "basic" plan. Insurers accept all such small groups that apply and accept all individuals in these groups. New pre-existing condition exclusions and/or waiting periods would not be imposed on small groups that change insurance companies or individuals who move from one small employer to a different small employer.

Continuity protections are extremely important and would make a significant improvement over current practices and should be extended to the most vulnerable group in the health insurance market—those people purchasing individual coverage. Thus, an individual who leaves a group plan and goes into the individual market would be subject to new waiting periods and pre-existing condition exclusions despite the fact that the individual previously had been covered.

*Discriminatory Rates*

Insurance industry *rating practices* are another practice that hurts consumers. *Community rating* spreads the risk as much as possible by setting a rate based on the average health costs of an entire pool (or community) of customers. This is the system originally used by Blue Cross/Blue Shield (BC/BS). It worked well until for-profit insurance companies began offering lower rates to young, healthy groups by basing rates on each individual groups's actual health experience, a practice known as *experience rating.* Once a young, healthy group ceases to be young and healthy, their rates go up dramatically and can quickly become unaffordable.

The insurance industry argues that, without experience rating, healthy groups would find coverage too costly. But these rating practices are not only unfair, they do not save money for healthy people. Insured healthy groups bear the high administrative costs of underwriting, as well as the uncompensated care costs for those priced out of private insurance.

Experience rating undermines the whole purpose of insurance-spreading risk and costs. In any insurance system, some people subsidize others who find it necessary to make claims. When we purchase insurance, it is in the hope that we will not need it, but that it will provide protection if it becomes necessary. Under experience rating, insurance companies charge higher rates to individuals and small groups based on health status, age, gender, and occupation/industry. Increasingly, hiring decisions must take into account the gender, age and health status of potential employees and their families because of this rating approach.

S. 1872 proposes some limited restrictions on the rates that may be charged to different small groups between 2 and 50 employees. In general, premiums for similar groups could not vary by more than 20 percent above or below the carrier's mid-

point—a 50 percent difference in rates. And after 3 years, plus or minus 15 percent—or a 35 percent difference in rates. Also, unlimited rate adjustments for age and gender composition of the group are permitted. In addition, insurers could raise premiums another 5 percent annually above increases for health inflation, presumably to take into account deteriorating health status.

These limits are too broad. Significantly higher rates will continue for small groups with any older workers, women under age 55, men over 55 or for any industry deemed unattractive by insurance companies. Under the 1990 medical rating table of a major commercial insurer, the annual premium for a 35 year old female is over $1,000 higher than the premium for a 35 year old male. For this same insurer the annual premium for a 55 year old male is over $1,700 higher than the rate for a 35 year old male.[1] This would certainly continue if there is unlimited age and gender adjustments.

The insurance industry argues that it is more equitable to charge lower rates to younger people because they have lower incomes. There are two problems with this argument. First, the industry is extremely inconsistent in its support for relating premiums to income. Women and disabled people also have much lower than average incomes, yet the insurance industry clearly often charges higher premiums to these groups. Second, insurance does little good if people can afford it when young and healthy, but find it unaffordable when they age or develop health problems.

The proposed rate bands leave small employers with significant financial incentives to avoid hiring women, older workers and disabled people.

The leeway in setting rates in S. 1872 allows insurance companies to continue to avoid risk, rather than spread risk. Insurance companies will still be able to entice lower risk groups with low premiums and raise rates when the group is no longer young and healthy.

According to a January, 1992 Congressional Research Service document,[2] the variations in rating practices allowed by S. 1872, even after 3 years, remain extremely broad. Insurers could develop premiums for a small group based on the assumption that individuals with certain risk characteristics would be ten times more costly than other individuals. This can happen because of the variation allowed for the individual's exact geographic location, age, sex, health risk factor, and administrative block of business.

MAXIMUM VARIATION IN RATING FACTORS, CURRENT PRACTICE, S. 1872 AND H.R. 3626

[Ratio of highest to lowest adjustment factor]

| | Current practice | S. 1872 | H.R. 3626 | S. 1227 |
|---|---|---|---|---|
| Case characteristics: | | | | |
| Age/sex | 3.12 | 3.12 | 1.67 | 1.32 |
| Geography | 1.99 | 1.99 | 1.00 | 1.00 |
| Industry | 1.71 | 1.00 | 1.00 | 1.00 |
| Subtotal | 10.57 | 6.20 | 1.67 (1) | 1.32 |
| Risk factor | 4.00 | 1.35 | 1.00 | 1.00 |
| Block differential | 1.41 | 1.20 | 1.20 | 1.20 |
| Administrative loading | 1.10 | 1.00 | 1.00 | 1.00 |
| Total | (2) | 10.04 | 2.00 (1) | 1.50 |

[1]Subtotal and total may not equal product of component factors due to rounding.
[2]Maximum total variation in small group rates cannot be estimated.

SOURCE: CRS analysis of legislative proposals.

We have preliminary results from a study we are doing on premium increases over 5 years under S. 1872, as compared to H.R. 3626 (Congressman Rostenkowski's Health Insurance Reform and Cost Containment Act of 1991).

Families USA has begun analyzing what the proposed changes in rating practices are likely to mean for small groups. We are looking at hypothetical businesses with ten employees (60% with family coverage) over 5 years. We have been looking at

[1] 1990 Medical Rates by Age and Sex, Aetna Life and Casualty, New York State (from Testimony to Maine Insurance & Banking Committee, Karen Olson, CLU, ChFC, President, Benefits Design Group, Inc., March 1991).

[2] Memo from Mark Merlis, CRS to House Committee on Ways and Means; subject: Health Insurance Rating Restrictions Under H.R. 3626 and S.1872, January 15, 1992. The following chart illustrates the maximum ratio of premiums under S. 1872, H.R. 3626 and S.1227.

what happens to the premiums for hypothetical groups when, over 5 years, one employee develops a chronic expensive condition and the workforce of that group changes from being composed of individuals who, based on their age and sex, are considered by insurers to be less expensive than average to being composed of individuals who because of their age and sex are considered more expensive than average. We have looked at the rating practices allowed by S. 1872, H.R. 3626 (Congressman Rostenkowski's Health Insurance Reform and Cost-Containment Act of 1991) and by the National Association of Insurance Commissioners.

Our preliminary analysis indicates that under S. 1872 a small group of ten employees could be paying a minimum of $12,000 more in health insurance premiums annually than would be allowed under H.R. 3626. This is primarily because S. 1872 allows unlimited variation for age and sex and contains no cost-containment provision. H.R. 3626, on the other hand, limits the variation in rates based on age and sex variables and allows small groups to use Medicare payment rates. We have not yet estimated the effects of allowed variation within a geographical area or different blocks of business.

Looking at the same small groups under the rating practices proposed by the National Association of Insurance Commissioners, a group of ten could be paying $24,000 more in annual health insurance premiums than under S. 1872. This is primarily because of the increased variation allowed for age and sex and health status. Under S. 1872, health insurance premiums for virtually any group of ten would more than double in five years. This illustrates why rating reforms, alone, will not make health insurance available to small groups.

## BENEFITS

We support the standard benefit package in S. 1872 with the addition of prescription drugs, family planning services and small cost sharing requirements. Last spring, we issued a report entitled, "Insurance That Doesn't Insure," in which we concluded that "barebones" coverage—that is, limited benefit packages—provides inadequate coverage, and is not attractive to employers. The "basic" benefit plan in S. 1872 is barebones.

We found evidence that many "limited benefit" plans reduce premiums through high co-payments, high deductibles and low lifetime caps on coverage. Approximately 22 States have waived mandates to allow the insurance industry to offer "limited benefit" plans. Many of those plans achieve lower premiums through high co-payments and deductibles (e.g., $5,000 deductible), severely limited benefits (e.g., few hospital days), and limits on total annual and lifetime dollar benefits, rather than through elimination of mandates—an approach that simply shifts health costs from premium payments to out-of-pocket payments.

Barebones plans that do not meet the needs of small groups have generated little interest.[3] There is evidence that most small businesses that offer health insurance usually choose plans with comprehensive coverage. Many States that have waived State mandates, restricted the quantity of services and added high costsharing are finding few takers their "limited benefit" plans.

## PAYING MORE GETTING LESS

In the face of escalating premiums, small businesses and individuals are forced to either drop coverage or reduce their coverage. This leaves families exposed to high out-of-pocket costs and/or inadequate lifetime coverage. The very peace of mind and security insurance is supposed to provide is unavailable under these circumstances.

S. 1872 proposes broad limits on the annual premium increases which may be charged to small businesses. These limits typically allow insurance companies to increase rates by whatever the company determines is its "trend." This amount is the rate charged to a new business. To this "trend" may be added an additional 5 percent for health status changes in a particular group.

The limits on annual premium increases are so broad that double digit premium increases will continue to be the norm. With medical inflation rising at double the rate of general inflation, with increased cost-shifting to private insurers for uncompensated care, and with increasing administrative costs, the "trend" is likely to remain in double digits.[4]

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[3] "Movement to Sell Basic Health Plan is Found Faltering," New York Times, November 10, 1991, p. 1.

[4] Health insurance premiums increased 12 percent 1987–88, 24 percent 1988–89 and 14 percent 1989–90. See Cynthia B. Sullivan and Thomas Rice, "The Health Insurance Picture in

Continued

Only systemwide reforms will accomplish the goal of containing costs. H.R. 3626 proposed use of Medicare-like rates for all employers who request them. This is a step in the right direction. Outcomes research and an advisory cost commission are positive measures to ensure quality care, but they are insufficient to put a clamp on rising costs.

Managed care, which if designed with the consumer in mind, may provide access to quality care. Federal standards are a welcome innovation. However, managed care cannot be relied on to stem rising costs.

Some types of HMOs—particularly staff-model HMOs where individuals must go to physicians based at a clinic who are paid on salary—have been able to achieve one-time "savings", from reduced hospitalization costs relative to conventional plans. In reality, these "savings" have actually resulted in increased costs for others, since hospitals charge others more to make up for any "losses" from HMOs. Managed care has thus resulted in cost shifting, not cost savings.

There is no evidence to support the claim that managed care plans can provide less costly care over time. Managed care premiums have been increasing at virtually the same rates as other health insurance premiums. Over the last 3 years, managed care premiums increased 15 percent, on average, while other insurance premiums increased 17 percent, on average.

### DEDUCTIBILITY FOR INDIVIDUALS

Full deductibility for individual policy-holders establishes equity between the subsidy received by businesses and individuals. However, individuals receive no assurance that their premiums will not continue to soar or that coverage will be available to them. The deductibility will be helpful for self-employed persons who already purchased individual coverage, but it may do little to encourage coverage for individuals who have not been able t purchase coverage. And as Stated previously, the rating limits and pre-existing condition limits do not apply to this group, which may mean insurance is unaffordable even with full deductibility.

### MEDICARE IMPROVEMENTS

The preventive services proposed for Medicare beneficiaries are welcome additions. However, what seniors really want and need is long term care. With our population getting older, and with more people aging into the 80's and 90's, it is essential that long term care protection be afforded to America's families. For frail and older people, the distinction between their chronic and acute care needs is a fine line at best, and the denial of chronic care would result in enormous hardships. Given the severe limitations of Medicare in covering long term care, and the lack of private insurance coverage in this area (with only 3–4 percent of the elderly covered by private long term care insurance policies), it is important that long term care coverage is included in health care reform legislation.

Also, we have been following the development of the long term care insurance market as the number of policies sold increased dramatically since 1987. Our concerns are that policies are not affordable for a large number of the elderly, and that those who have purchased these policies, often at great personal expense, have encountered great difficulties in getting the insurance companies to pay their claims. Until such time that a comprehensive long term care plan is enacted, there remains a need for consumer protections against long term care insurance abuses.

### CONCLUSION

Comprehensive reform, including systemwide cost containment, is the only alternative to solving our health care crisis. Small steps cannot guarantee that insurance will be more accessible to small businesses. Positive improvements in S. 1872 include: extending the continuity of coverage protections to the individual market; eliminating—discriminatory practices in setting premium rates; a comprehensive benefits package; and addressing the issue of long term care.

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1990," *Health Affairs,* Vol. 10, No. 2, Summer 1991, pp. 104–115; Jon Gabel, Steven DiCarlo, Steven Fink and Gregory deLissovoy, "Employer-Sponsored Health Insurance in America," *Health Affairs,* Vol. 8, No. 2, Summer 1989, pp. 116–128; and Jon Gabel, Cindy Jajich-Toth, Gregory deLissovoy, Thomas Rice and Howard Cohen, "The Changing World of Group Health Insurance," *Health Affairs,* Summer 1988, Vol. 7, No. 3, pp. 48–65.

## Prepared Statement of Bryant L. Welch

Chairman Bentsen, Members of the Committee, good morning. I am Dr. Bryant Welch, Executive Director for Professional Practice of the American Psychological Association. I am a board certified clinical psychologist and a licensed attorney. The American Psychological Association, as the largest membership association for over 100,000 psychologists engaged in academia, research, and the practice of psychology, greatly appreciates the opportunity to testify before this Committee in its vital efforts to remedy the disintegration of high quality, affordable health care in America.

The current health care system encourages an irrational and self-defeating focus on short-term and simplistic solutions to long-term and complex problems. This current health care system irrationally advances higher long-term costs by promoting insurance, administrative, and financing practices which curtail access, coverage and quality in the short-term

As this Committee knows, national health care costs have run amok in America. Conservative estimates place the current health care price tag at $817 billion, 14% of the GNP and growing twice as fast as the rate of inflation. In 1990, business spent, on average, $3,000 per employee on health insurance, a rate which has recently increased over 20% annually. At the same time that costs have skyrocketed, access to care has plummeted. The number of uninsured citizens has risen dramatically from the 34.6 million figure, as cited at the introduction of S. 1872 just a few short months ago, to current estimates of from 37 to 40 million uninsured, with almost 100 million citizens inadequately covered. Finally, while costs and the numbers of uninsured have soared, quality has actually declined as patients have been forced into inappropriate care by scant insurance coverage or by managed care entities which have dictated less cost-effective and lower quality "quick fixes" to medical and psychological care.

In general, the system promotes snowballing costs, instead of controlling them, with approaches to care which present the illusion of cost-saving but in the end are costing our nation much more. Several examples should sufficiently highlight the irrationality inherent in the current system's dysfunctional approach to managing the triad of cost, coverage, and quality. First, the bureaucracy has spurred an ever-increasing orientation toward dramatically costlier crisis and inpatient care, as outpatient and preventive coverage has eroded and costs have been shifted to consumers and the public system. The best example of this sort of paradoxical mistreatment has recently surfaced in the $4 billion private psychiatric hospital industry, where deregulation stimulated the construction of a tremendous number of expensive new beds which were filled largely with children who could have been treated more cost-effectively in outpatient settings, but where insurance policies paid for the inpatient care but not the outpatient.

Second, even more irrationally, the federal bureaucracy has not attempted to control costs or improve quality in the long-term by producing consensus treatment guidelines or supporting outcomes research in order to standardize which treatments work most cost-effectively. Instead, under the euphemism of "competition", it has permitted the free proliferation of managed care approaches, which have simplistically sought to control costs through onerous treatment restrictions based on inadequately standardized or publicized criteria; invasions of patient-provider privacy and dignity; and review and appeal procedures too complicated for consumers to understand or follow. As is increasingly evident, utilization review and other managed care mechanisms have themselves increased costs and lowered the quality of care by curtailing the provision of early preventive care, such as outpatient psychological services, thereby ignoring untreated illness which nonetheless simply resurfaces in the long-term via much more expensive emergency and hospital visits.

Finally, the present health care administrative, financing and delivery organization has fostered the development of a massive and unwieldy bureaucracy of over 1500 different insurers, all with their own independent underwriting, billing and paperwork procedures, which, if unified into a

single administrative process, could fully fund comprehensive coverage for all uninsured Americans according to a recent GAO Report.

The current system has thus addressed spiraling costs and lack of access, coverage, and quality not with a logical focus on long-term, preventive approaches to reforming its irrational encouragement of inefficiency and low quality, but rather with a view toward short-term "quick fixes" which have so obviously failed as solutions. Clearly, such a system perpetuates the worst of all possible worlds, with its irrational and short-sighted focus providing the infrastructure for the overwhelming crisis now confronting this Committee.

The Health Care Insurance System Has Historically Developed With an Illogical Concentration on Covering the Most Expensive Late-Stage Treatments Instead of Focusing on More Rational, Cost-Effective Early-Intervention and Preventive Approaches.

The history of private health care insurance in America illustrates why the current system is in crisis, and where it must direct its attention to alleviate it. Private health insurance developed in the mid-19th century, but failed to prosper because of high administrative costs, commissions, profits and overhead, in addition to adverse selection and insurer inability to spread risks through group enrollment (Starr, 1982). Only accidental injury or death and industrial life insurance policies flourished because they covered catastrophic injuries and the expenses of final illness and burial, those that the middle class could not afford. For less severe sickness, patients needed insurance against lost earnings more than payment of medical expenses. As hospital expenses rose in the 1920s, however, the middle class generated demand for inpatient coverage which opened up new markets for health insurance and stimulated the emergence of BC/BS and others. Finally, as outpatient medical services, diagnostic procedures, and medications similarly became too expensive for the middle class, they too began to find a niche in private insurance. Historically, then, the trend favored the emergence of insurance coverage only against those treatments, procedures and settings which became too expensive for the consumer. Such a system does little to encourage rational health care expenditures and unwittingly encourages utilization of expensive procedures.

APA believes that one of the solutions to redirecting the focus of reform toward efficient and rational health care delivery and financing is to abandon the exclusive emphasis on curative late-stage care in favor of prevention and offset of disease before it becomes more serious and costly to the system. Senate 1872 and other reform proposals have already partially envisioned this need to translate the irrational historical trend into a longer term, prevention-oriented approach by covering such services as prenatal, well-baby and child care.

It is critical at the same time, however, that the bill fully recognize and cover mental health care services, which offer the most significant opportunity for achieving major cost savings by preventing mental and resulting physical disease from escalating into much greater problems which are those that have been so inundating the system with their massive late-stage costs.

Evidencing The Irrationality of the Current System is Its Failure to Adopt a Preventive, Long-Term Conceptual Approach Including Mental Health Care

Inclusion of mental health care coverage can restore rationality to the system. The best outcomes in health care occur when early cost-effective treatments preclude the need for more expensive later-stage treatments of more serious illness. Mental health care seeks and attains just these ends. By denying access to needed mental health care in national bills, permitting managed care firms and indemnity plans to slash benefits, and allowing untrained or non-specialist utilization reviewers to dictate standards of care and cut off treatment accordingly, the system perpetuates the irrational decision-making mechanisms so prevalent throughout the general health care bureaucracy. The cost savings of including mental health occur through several different but interrelated avenues.

A massive amount of medical consumption is a ramification of untreated psychological illness and could have been prevented with appropriate mental health care services

Mental health care can reduce the irrational cost to the system of mistreating or incompletely treating many illnesses through medical avenues when their symptoms actually mask psychological disorders. For example, 60% of all medical visits to general physicians are by patients with no underlying organic medical problem. Instead, these patients are suffering from exclusively psychological problems. This figure rises to about 90% if stress-related and psychosomatic illnesses, such as peptic ulcer, ulcerative colitis, irritable bowel syndrome, and hypertension, are figured in (Cummings & VandenBos, 1981, 1988). Other studies have confirmed prevalence rates as high as 40% for primary care patients with overt mental disorders, and 25% for those with disabling psychiatric disorders (Jencks, 1985; Orleans, 1985).

Unfortunately, the majority of non-psychiatric physicians are untrained or inexperienced in the diagnosis and treatment of mental disorders, typically receiving less than three months of training in the field of mental health (AJP, 135, 29-32). Further, "primary care physicians tend to underdiagnose and underreport psychiatric morbidity" (Kessler et al., 1985) and "a large proportion of patients suffering from mental disorders . . . seen in the general health sector . . . are not necessarily diagnosed accurately and . . . not always treated or referred properly" (Pincus et al., 1983). It is thus no surprise that they usually perform a myriad of unnecessary tests and rely ultimately only on tranquilization and improper drugging, which is not only ineffective but also leads to consequential expenses such as drug dependence, side effects, and serious medical complications. Inappropriate drugging and tranquilization, unlike psychotherapy, appears unlikely to reduce general medical costs (Jones, 1979; Kessler, 1982), and very likely increases it due to complicated sequelae. Even the American Medical Association and the American Psychiatric Association, in a recent legal brief, argued that in general, "non-psychiatric physicians" tend to prescribe ineffective doses and not to respond properly to a patient's failure to improve" (CAPP v. Rank, 1989). Without mental health coverage, such patients will continue to submit to the inappropriate medical procedures and druggings of general physicians, at great cost and with little chance of remission.

Not surprisingly, where patients have access to psychological services, they show a decreased need for medical care and substantial medical cost offset savings

People with untreated mental health problems tend to overutilize medical services, averaging twice as many visits to their primary care physicians as those without a mental disorder (Borus, 1985). A growing body of empirical research indicates that appropriate mental health services achieve substantial medical cost offset savings by effectively treating the underlying psychological problem. In one study, for example, a review of over 60 investigations of psychotherapy effects on medical utilization found that 85% of patients showed marked declines in medical usage after therapy, averaging a decrease of 73.4% for inpatient and 22.6% for outpatient services (Mumford et al., 1984). In another more recent study, three hundred veterans with inordinate medical service utilization reduced outpatient medical visits by 36% when they received more appropriate limited psychotherapy. Control groups which received no psychological treatment actually increased medical utilization (Massad et al., 1990).

Moreover, psychological care can reduce physician and hospital costs for patients with many physical illnesses which respond well to psychological interventions in addition to medical treatments. For example, a study of over 2000 patients with diabetes, ischemic heart disease, hypertension, or reversible airway disease found that over three years, most of the 700 patients receiving psychotherapy had medical costs between $284 and $309 lower than comparison groups who had no psychological care (Schlesinger et al., 1983). Twenty-five per cent of the therapy group had a total offset; that is, their mental health care fully paid for itself in lowered medical costs.

Since over 40% of the American public suffers from these disorders, the cost savings of including mental health care in their treatment plan could be enormous.

Untreated psychological disorders not only burden the health care system with increased medical utilization, but also exact a monumental toll by inducing maladaptive behavior patterns which drive up inefficiency and cost even more

Improper utilization of medical services by mental health patients is only the tip of the expenditure iceberg for untreated mental illness. Without appropriate treatment, patients often resort to self-defeating and addictive behaviors as well as inappropriate, inefficacious, and dangerous self-treatments. For example, the untreated patient with a serious anxiety or depressive disorder may attempt to alleviate the condition with pathological over- or under-eating, stimulants or alcohol, or even dangerous, risky or antisocial behaviors. The research literature is rife with examples of the high prevalence of comorbidity of depression or anxiety with other serious addictive and self-defeating behaviors which needlessly multiply the irrational, unjustifiable costs of the health care system generally. For example, a 1988 estimate of the cost of alcohol and drug abuse to society predicted total cost at over $143 billion. Life-time prevalence rates of alcohol abuse and dependence have been estimated at 16% for men and 9% for women (Bromet, 1990). Moreover, alcohol and substance abusers further drive up the cost to the system through heavy use of medical services: one recent study determined that chemically dependent patients who did not receive mental health services increased their medical costs by 91% during the study period, in comparison to actual decreases in the control samples who received mental health care (Cummings, 1990). Other studies have shown that substance abuse treated with mental health services results in massive 20% medical cost offsets, reaching savings of 40% when prevention of absenteeism, lost productivity, and accident benefits is figured into the calculus (Jones, 1979).

Untreated mental illness not only spurs the development of medical service overutilization and maladaptive behavior responses, but itself can directly precipitate serious physiological illnesses which might have been prevented if treated at their psychological source

There should be little surprise that mental health problems permeate 7 of the 10 leading causes of death and figure in all of the top five health problems confronting American businesses. Adequate treatment of the original psychological and emotional stressors can preclude development into more expensive and life-threatening physical disorders. Mental health services have been found effective not only in treating but also in inhibiting the development of stress and anxiety into more expensive physical illnesses such as ulcer and even immune disorders and cancer; negating the development of self-defeating behaviors, such as eating disorders, smoking, obsessive compulsive behavior, self-inflicted injuries, accidents, child and spousal abuse, and suicide; and, as already intimated, precluding the need for dangerous self-treatment with alcohol, illegal drugs, and prescription abuse.

Psychological services are not only necessary to offset major medical costs, prevent self-defeating and maladaptive responses, and preclude the progression of psychological distress into major physical illness, but also, to reduce the costs and treat the overwhelming suffering and distress caused by the psychological disorders themselves.

As this Committee is doubtless aware, over 30 million American adults have a serious mental disorder other than alcohol or substance abuse, costing society over $130 billion annually (Rice, 1990;EBRI, Feb. 1990). However, 1 in 3 patients fails to get appropriate mental health treatment (NIMH, 1989), largely because of the unavailability of insurance coverage (Frank & Kamlet, 1989). Finally, 15% of the work force need mental health services at any point in time, with stress, anxiety, and depression accounting for an average of 16 lost work days each year per employee, costing $10 billion per year just for absenteeism due to depression (NIMH, D/ART Office, 1990).

As noted above, patients with diagnosable mental illness, especially with restricted mental health benefits, tend to see family physicians who are untrained and ill-equipped to handle their mental health needs. With appropriate and low-cost mental health interventions, however, depression and most other major mental health problems are highly treatable, and their potentially gargantuan indirect and long-term costs, such as disability and mortality, preventable. Indeed, as recent meta-analyses have indicated, mental health services including psychotherapeutic techniques not only result in extremely favorable outcomes but also stimulate long-lasting remissions, greatly supporting the notion that psychological treatments have both short-term acute care and long-term preventive effects (see, e.g., Robinson et al., 1990; Nietzel et al., 1987).

Psychological services also provide the most rational means of preventing lost productivity and absenteeism in the work force. About half the $130 billion societal toll imposed by mental illness is attributable to lost productivity in the workplace (Rice/ADAMHA, 1990). Mental illness is as functionally disabling in the work force as a serious cardiac or pulmonary condition, hypertension, and even diabetes (Wells, 1989). Only cancer and stroke have been determined to be more limiting to a worker's daily life activities (MHPRC, 1990), and when disability is linked to work productivity, mental illness is the most restrictive condition, with 76% of those disabled by mental illness showing impairment in their work. Moreover, alcohol and drug abusers are late and sick three times as often, four times more likely to have an on-the-job accident, and five times more likely to file a workers' compensation claim, as the average worker (Business and Health, Oct. 1989).

Mounting evidence has shown that greater provision of psychological services could improve worker productivity and prevent absenteeism for both the worker and her family. Many large corporations have relied on wellness and employee assistance programs (EAPs) with referrals to outpatient mental health services for dramatic cost savings. For example, McDonnell Douglas estimated that their EAP program saved them $5.1 million in 1988 alone in medical cost and productivity loss offsets.

The inescapable conclusion, therefore, is that patients with serious underlying stress and emotional problems who are not treated with mental health services through lack of coverage or broad-brush assaults by managed care will not get over their problems, but will come back to haunt the system with increased morbidity and mortality and to impose a much higher price tag, through over-usage of high-technology, hospital and drug treatment, and more serious illness than that which would have been attached to preventive and early interventions such as psychological services. It is simply more rational and economical to meet patients' needs with targeted, safe and effective psychological services as early as possible.

Applying this rationale to the S. 1872, we have two major areas of concern. Our first concern with the bill is that it reduces the overall availability of mental health care in this country. On its face, it is clear that in the "basic package" offered in the proposal, mental health care is not included. Thus, to the extent people are covered under the basic plan, society will bear the aforementioned costs of more expensive and less effective medical care, and/or bear the brunt of untreated psychological problems with their impact on subsequent costs to the general health care system and to society.

The problem runs much deeper however. Mental health programs across the country have been victimized by "adverse selection" in which those employers who do provide mental health coverage find that people needing the coverage switch to those programs effectively eliminating the spreading of the risk across the population. Thus, the mental health claims of those who have the policies become expensive and, more importantly, since people with mental health problems tend to have greater need for medical care overall, it serves to attract those people with greater utilization. If both policies had mental health coverage, this problem could be avoided and the mental health coverage costs would remain quite modest, but with the differential coverage the standard package will eventually become prohibitive in cost compared to the basic.

But of even greater concern than the gap in coverage and the adverse selection problem is the impact the legislation would have on those individuals who currently do have adequate mental health coverage but whose employers under this legislation would be free to opt for the basic plan, thereby eliminating their mental health coverage. This would clearly be contrary to the objectives of the legislation if we consider that an estimated 17 million employees of small businesses plus their families currently have mental health coverage under state mandates. Thus, it seems clear that the net effect of this legislation will be to jeopardize badly needed mental health coverage for millions of Americans and to set the stage just a few years down the road for massive increases in overall cost as psychological problems turn to physical problems, as maladaptive behaviors leading to serious health problems, and as the cost for untreated mental illnesses themselves wreak their havoc upon our health care system.

In short, without mental health coverage people with psychological problems lead to a massive overutilization of our more expensive medical care system, a much greater likelihood of psychosomatic and other serious stress-related illnesses, continued maladaptive behavior driving future health care costs even higher, and our society will continue to pay the cost of untreated mental disorders such as depression and alcohol and drug abuse.

The solution to this problem is to provide the same level of mental health care in both packages and make at least minimal mental health treatment available to all, both to prevent the adverse selection process which will greatly hamper the standard package in the S. 1872 and to make sure the plan does not do the opposite of what is intended by reducing the level of care for millions of Americans who are currently protected by mandates and are working for small businesses.

Can we afford it?

It is ironic that with the waste represented by not having adequate mental health coverage included, some argue that it is too costly to include mental health care in the package. The fact is that outpatient mental health care would only increase the cost of the package by two percent and adding both inpatient and outpatient would only lead to a total cost increase of six percent (Congressional Research Service). If we consider the estimated 40 percent of the policy cost which is to be spent in administration, it seems remarkably shortsighted and ill-advised to single out the mental health benefit for exclusion.

It should be acknowledged, however, the mental health benefit has been victimized by the same irrational bias for expensive treatment that we find in the overall medical system. Specifically, "to save costs," insurance companies have either reduced outpatient coverage, thereby forcing patients either to forego care (with the above described ramifications) or to seek out much costlier inpatient setting accommodations. Thus, in many cases reports of "increases in mental health costs" have been a function of poorly-designed benefit structures rather than any inherent cost problem with mental health care.

Recognizing the unique burdens on small employers associated with health coverage, the APA asked one of the nation's leading health economists to test the applicability of the Congressional Research Service findings for employers with 50 employees or less. Having examined the individual and family utilization experience of over 63,000 such employees drawn from over 1200 companies around the country, the preliminary report strongly supports the affordability of the mental health coverage included in S. 1872's Standard Plan.

This economic model can also be applied to measure the cost to small employers of providing the minimum mental health benefit in Mr. Rostenkowski's companion proposal which is based on Medicare. While slightly higher, the cost associated with the inpatient and outpatient mental health benefit is still only about seven percent of the premium cost.

As a third alternative, the report tests an "integrated minimum benefit" for mental health innovatively designed to take full advantage of the efficacy and lower cost of outpatient care by setting an overall dollar limit for

mental health care in either an inpatient or outpatient setting. The evidence suggests this approach would cost small employers even less than the other minimum mental health benefits. The report's author and the APA would welcome the opportunity to share these important findings with the Committee in the near future and ask that the report be added to the record. When the report is final, we believe it will clearly demonstrate small employers can afford an adequate mental health benefit and that there is simply no cost-based rationale for the sub-standard option and its ill-advised exclusion of mental health.

This bill would be greatly improved by setting an affordable minimum mental health benefit as a floor and by closing the loophole represented by the sub-standard package. A single uniform standard would address the problems associated with undermining state mandated benefits, decrease the risk of adverse selection, and represent a positive step toward more comprehensive reform.[1]

Our second area of concern is with managed care. The bill as written would undermine quality of care, especially mental health care, by eliminating state laws which establish basic guidelines for the managed care industry protecting patient access to appropriate services, safeguarding patient rights, and limiting financial conflict of interest inherent in certain managed care systems.

S. 1872 can be significantly improved by replacing the state laws regulating managed care entities with a set of explicit mandatory federal guidelines that emphasize consumer protection, eliminate certain practices that lead to inappropriate denial of services and protect appropriate clinical standards of care.

It is our position that managed care, and particular forms of managed care such as utilization review, should and must be subject to regulatory oversight to ensure accountability and safeguard basic quality of care. Managed care today, in various forms, is a virtually unregulated multi-billion dollar industry in the business of delivering health care to citizens across the country. We believe the industry has evolved to the point that basic safeguards must be established to control actual and potential abuses regarding patient care.

Some states have established managed care regulations aimed at encouraging patient access to a range of services, patients' right to due process, confidentiality and information about claims determinations. Some laws attempt to limit situations where financial conflict of interest may exist for an entity or person when there is a forced decision between saving money or providing necessary care. Other features of the laws include requirements for qualified, credentialled personnel to review and manage patient care. The insurers and managed care companies strongly oppose these various requirements arguing their services would become prohibitively expensive and ineffective.

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1. A second aspect of state manates is the freedom-of-choice that gives patients the right to access the type of qualified mental health provider they prefer. It is extremely important that S.1872 make it very clear that qualified mental health providers are allowed to provide services as they are in virtually all state and federal programs. Benefits without access to providers are illusory. In two-thirds of the counties of this country, there is not one practicing psychiatrist (Applied Management Sciences, 1988). When we add psychologists to the pool of eligible providers, about forty percent of that gap in coverage is closed, and when we add social workers and psychiatric nurses, an even higher percentage of our nation's population gains access to a qualified mental health professional. These freedom-of-choice mandates serve to make badly needed mental health care available and to see that it is delivered in a pro-competitive health care environment.

Mr. Chairman, we will not go into these issues in any greater detail given the purpose and scope of today's hearing. However, we challenge the assertions of insurers and managed care entities and suggest we must give responsible consideration to consumer rights and quality of care. Growing evidence of patient dissatisfaction and abuse is available, including recent court decisions which have reviewed situations of negligence and abuse in managed care systems.

These problems can be curbed and quality maintained without compromise to the efficiencies which managed care has the potential to provide. S. 1872 must establish a set of federal standards for managed care that includes at least the following:

1. protect confidential patient records and progress notes;
2. require qualified peer review and all appeals by peer providers;
3. provide full consumer and provider access to review criteria and determinations;
4. maintain liability for negligent utilization review determinations;
5. provide comprehensive and efficient appeals procedures which safeguard patient rights and due process.
6. protect consumers from certain conflicts of interest in managed care arrangements.

In conclusion, we would like to emphasize that our testimony today has dealt exclusively with the fiscal and economic implications of the legislation. We do this to acknowledge the economic pressure which we know you and others are under in this health care crisis. In no way, however, do we wish to overlook the staggering humanitarian dimension to providing adequate mental health care. We do believe that given the well-documented preventive impact of mental health services, sound fiscal planning dictates the inclusion of the benefit.

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# COMMUNICATIONS

## STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association (AHA), on behalf of its nearly 5,400 institutional members, is pleased to submit this statement for the record regarding S. 1872, "Better Access to Affordable Health Care Act of 1991." S. 1872 would reform the small group health insurance market to make health insurance more accessible and affordable for small businesses. It would also make recommendations on the development of a Federal certification process for managed care plans and utilization review programs. We have reviewed the bill, and although we support the basic insurance reforms, we have concerns about the provisions relating to standards for utilization review programs.

As we Stated in testimony before the senate Committee on Labor and Human Resources on July 31, 1991, the AHA supports a continued strong role for private insurers in the health care market but recognizes the need for substantial reform, particularly in the small group market. We applaud the sponsors of S. 1872 for the reforms they have proposed to improve the accessibility and affordability of health insurance for small businesses, including eligibility and availability guarantees, limitations on preexisting condition exclusions, and restrictions on rating practices.

Our primary problem with the bill concerns the provisions related to standards for utilization review programs. specifically, we are concerned about the narrow scope of the certification requirements to be addressed by Federal standards; the elimination of provider reimbursement for costs associated with responding to utilization review requests; the timing of the preemption of State laws; and the lack of opportunity for public comment on the Federal standards during their development.

### CERTIFICATION RETIREMENTS TO BE ADDRESSED BY FEDERAL STANDARDS

The bill would preempt State statutes and regulations which restrict external utilization review programs. In place of State laws, the Secretary of Health and Human Services (the secretary) would establish Federal standards for certifying utilization review programs. The Federal standards would address:

- qualifications of individuals performing review activities;
- procedures for evaluating the necessity and appropriateness of health care services;
- timeliness with which determinations of necessity and appropriateness are made;
- procedures for the operation of an appeals process; and
- procedures for ensuring compliance with all applicable Federal and State laws designed to protect the confidentiality of individual medical records.

The proposed Federal requirements are less comprehensive in scope than many of the State laws that would be eliminated. We are not opposed to the development of a Federal certification program; however, we do not believe that the requirements set forth in the bill are adequate to assure the reliability of review results, to guarantee that patients and providers are made aware of utilization review requirements, or to minimize the administrative burden associated with external review.

We recommend that the requirements for Federal standards be expanded to address the issue of reliability and efficiency of external review as well as to ensure that both patients and providers understand the conditions under which care will be covered. specifically we recommend adding provisions to Section 402(b) (2)—"Qualified Utilization Programs" requiring inclusion of the following standards.

- **Appropriate involvement of physicians in the development of medical protocols.** The criteria and standards used to assess medical appropriateness must be established with input from practicing physicians to ensure that they

are reasonably consistent with accepted medical practice. The function of utilization review firms should be to determine whether the care they review is consistent with generally accepted clinical practice **as defined by the physician community.**

• **Appropriate targeting of review processes to limit administrative costs and increase the efficiency of review programs.** It is clear that the utilization review process can be made much more efficient by targeting review at those conditions and procedures which are most likely to result in utilization or quality problems. Based on the medical literature and previous experience, utilization review firms should be able to identify those areas for which review is most effective and focus their efforts accordingly. Targeting review in this manner would increase the efficiency of utilization review and decrease the costs for the review firms as well as for providers.

• **Adequate provider access to utilization review reviewers.** We were pleased that a standard related to procedures for the operation of an appeals process was included in the bill (Section 412(b)(2)(D)). However, in order to avoid unwarranted denials and to minimize disruptions in the delivery of care, we believe that it is important to require utilization review firms to make staff accessible to patients and providers seeking certification for admissions or responding to reviewer questions.

Specifically, we recommend that the standards require that utilization review staff be available through a toll free telephone number to respond to inquiries during the normal business hours of the provider's time zone. A procedure for managing after hour inquiries should be specified.

• **Public availability of review requirements and the standards of medical appropriateness used.** Unless patients and providers are informed of the utilization review requirements used by the health benefits plan, their effect on benefits, enrollee obligations, and potential sanctions, they cannot be expected to comply with them. If patients and providers are not made aware of this information, payment for services that should be covered by insurance plans may be denied because "proper procedures" were not followed. It is untenable to put patients in the position of being required to follow procedures that are not explained to them in order to obtain medical care.

### PROVIDER REIMBURSEMENT FOR COSTS OF RESPONDING TO UTILIZATION REVIEW REQUESTS

The bill would eliminate any State laws requiring utilization review programs or managed care plans to pay providers for expenses associated with responding to requests for information. There is no indication that Federal standards would be implemented in place of these State laws. Utilization review firms often ask not only for access to patients' medical records, but also to interview patients, add documents to the medical records, and coordinate discharge planning. This can add significant administrative costs for health care providers. Requiring that utilization review firms reimburse providers for the direct costs of review provides an incentive for them to limit their requests to only that information which is truly necessary. If review firms are able to shift the costs of their review process to providers, they have no incentive to be efficient, and it is impossible to assess the true cost effectiveness of their programs.

Optimally, we recommend that a standard related to provider reimbursement be included in the Federal requirements for certification. If this is not possible, we urge the committee to delete the provision preempting State laws requiring utilization review programs or managed care plans to pay providers for the expenses associated with responding to request for information need to conduct utilization review (Section 402(c)(1)(I)).

### TIMING OF THE PREEMPTION OF STATE LAWS

The bill does not time the elimination of the State laws to coincide with the implementation of the Federal standards. The bill requires that Federal standards be established within 24 months of enactment of section 402, "Federal Certification of Managed Care Plans and Utilization Review Programs." The preemption of State laws and regulations restricting managed care plans and utilization review programs would become effective upon enactment. This would leave a potential gap of 2 years during which there would be no standards governing the activities of these programs.

We recommend that the effective date of State law preemptions be timed to coincide with the effective date of the Federal qualification standards to be issued by

the Secretary. This would prevent any gap between elimination of State protections and establishment of Federal protections.

OPPORTUNITY FOR PUBLIC COMMENT ON FEDERAL STANDARDS

We are very troubled by the fact that the proposed mechanism for developing standards would not provide any opportunity for public comment. The bill would require that the secretary, in consultation with the newly created Health Care Cost Commission, establish Federal standards for utilization review certification. This process would preclude public comment on the standards, and we do not believe that consultation with the commission would provide an adequate opportunity for consumer and provider input.

We strongly recommend that Section 402(b) (1) and (2) be modified to require that Federal standards of both qualified managed care plans and utilization review programs be established by regulations to be promulgated by the Secretary. This would ensure an opportunity for public comment on these issues which have such a significant impact on the delivery of health care.

We appreciate the opportunity to submit this statement to address these important issues.

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STATEMENT OF DR. WILLIAM G. DROMS, CFA, PROFESSOR OF FINANCE, GEORGETOWN UNIVERSITY

[Critical Analysis of the Government Accounting Office (GAO) Report on "Medicare: Effect of Durable Medical Equipment Fee Schedules on Six Suppliers' Profit Margins" (November 1991)]

INTRODUCTION

GAO compared suppliers' costs with revenues for Medicare and non-Medicare business to "assess the effect of the change from reasonable charge to fee schedule reimbursement on suppliers' revenues and to analyze suppliers' costs." (p. 3 of GAO Report). In examining the GAO Report, anyone at all familiar with the home medical equipment (HME) services industry would be shocked by its central conclusion: namely, that the six companies examined apparently operate at an overall loss, while earning very large profits on their Medicare-reimbursed business id experiencing large losses on their non-Medicare-reimbursed business. GAO finds that the average profit margin for Medicare business is 19 percent while the average profit margin for non-Medicare business is–24 percent (loss) (Table 1, p.4 of GAO Report). Overall profitability is estimated at a loss of –2 percent.

The obvious inaccuracies in the GAO Report stem from the extremely small sample size and the accounting techniques used. In fact, the sample size is so small and the accounting techniques used so tenuous that the only appropriate analogy would be to assess the profitability of the retail grocery industry by visiting the corner grocery store, pricing out a few selected items and extrapolating the results to the industry in general.

Described below are three major flaws in GAO's sampling technique and two major flaws in its accounting methodology that make GAO's results completely useless as a guide to setting rational Medicare coverage and payment policy.

ANALYSIS OF REPORT'S FLAWS

*(a) Sampling Technique*

GAO selected six suppliers "for detailed review." (p. 3 of GAO Report). But this sample size is so small and patently nonrepresentative of the services industry that to call it "trivial" would be a gross overstatement. The sample suffers from so many limitations that it is totally useless as a guide to establish coverage or payment policy for Medicare. *Indeed, on its very first page, the Report's authors flatly concede that the results are of no value in assessing the true state of profitability within the HME industry: "Because of the amount of work involved in this process, we could not select enough suppliers randomly to yield projectable results"* (page 1 of GAO Report). If GAO begins its Report by stating flat out that the results are unreliable due to small sample size, then what is the point of the exercise?

To select this sample, GAO identified "1,583 individual Medicare HME suppliers with 1986 Medicare-allowed charges of over $150,000" reimbursed under the Medicare Part B "DME" benefit (p. 13 of GAO Report). Out of these 1,583 suppliers, they then selected six. Thus, the sample looks at a grand total of 0.4 percent (four-tenths of 1 percent) of the suppliers GAO could identify.

In an attempt to overcome its inability to "cover a statistical sample of suppliers that could be used to project the universe" (p. 13 of GAO Report), GAO selected a

"judgmental sample representing a cross section of suppliers based on the following criteria: geographic diversity, States with a high Medicare enrollment, and a mixture of different suppliers based on revenue from Medicare" (pp. 13–14 of GAO Report). Among States selected to provide "geographic diversity" are: Georgia, North Carolina, Florida and Maryland—two geographically contiguous States in the Southeast and one Eastern State just north of the Mason-Dixon line. To these four southeastern States are added Texas and California.

Having selected a small, admittedly nonrandom sample, GAO then proceeded to reduce the sample even more by examining only one site of those suppliers with multiple locations—a process akin to visiting the neighborhood Safeway supermarket in order to determine how the national grocery chain is doing. The net result of this further limitation on the already nonrepresentative data was that profit margins computed in the study "are based on annualized supplier revenues of $7,072,000 for 1988."

In fact, this sample is even smaller than the roughly $7.1 million identified: the word "annualized" in the previous sentence refers to the fact that the authors examined revenue and cost data for 1 to 4 months' operations (according to the Report) and extrapolated those results to produce "annualized" revenues. Two suppliers reported that the GAO auditors looked only at data for October of 1988 and "annualized" that 1 month's data to simulate a full year's results. At best, the authors audited no more than $2,000,000 in actual revenues. Even if we accept the $7,072,000 "annualized" figure, this number must be further reduced since the firms' weighted average total revenue from Medicare was 49 percent (p. 4 of GAO Report). Thus, of the $7,072,000,49 percent or $3,465,280 would be attributable to Medicare. **This Medicare revenue volume is truly minuscule in comparison to the reported 1989 total Medicare payments to suppliers of $1,400,000,000. In fact the GAO revenue sample measures a grand total of 0.25 percent (one-quarter of one percent) of industry-wide Medicare revenues.**

*(b) Accounting Methodology*

After selecting this minuscule, nonrandom, nondiversified sample, the authors then proceeded to examine unaudited financial data to construct a new cost accounting system in an industry in which they had no experience, in spite of the position of experienced financial executives in this industry that such records are impossible to construct. Surely, any recent accounting graduate knows that unaudited financial data from small businesses are notoriously nonrepresentative. GAO further compounds this problem by then inventing a new cost accounting system for companies in an industry with which the authors have absolutely no practical experience. After all that, the Report then goes on to "annualize" 1 to 4 months' experience to approximate 1 year's results.

As well, the Report presents numbers of "profitability," a term which is never clearly defined. A careful reading of the Report indicates that "profits" are revenues minus the sum of direct costs, indirect costs and overhead costs for some undefined period of time (1 to 4 months) which are somehow "annualized" to simulate 1 year's results. The Report makes no mention of taxes, so presumably the results are pretax and presumably all expenses other than taxes are included in the three categories of expenses in the Report. GAO's process of "annualization," however, remains a mystery. Two CEOs of suppliers included in the study indicated that GAO examined only the month of October 1988. October may or may not be a "typical" month, but surely any business person knows that profitability varies from month to month and multiplying 1 month's results by 12 will not produce an income statement that even approximates the actual results for the year.

## OVERALL RESULTS

The overall results of the GAO study are startling, even incredible, for two reasons: First, the GAO findings on overall profitability are at extreme variance with the much larger independent studies of this industry undertaken by independent third parties. Three major industry surveys during the last 3 years, undertaken on behalf of the National Association of Medical Equipment Suppliers (NAMES), were completed by Dr. William G. Droms, a Chartered Financial Analyst and Professor of Finance in the School of Business Administration at Georgetown University. Additional independent surveys have been undertaken by Dr. P. Ronald Stephenson, Professor of Marketing in the Graduate School of Business at Indiana University-Bloomington. These surveys all present results based on independent industry assessments conducted by experienced researchers. All survey results during the past 3 years have found industry-wide profit margins (measured as return on sales, calculated as net income after tax as a percent of revenue) to be approximately 5.5 to 6.5 percent. This level of profitability has been found consistently over the past

three years by all of the independent surveys and is at extreme variance with the GAO finding of overall profitability of –2 percent. The most recent NAMES results are based on financial data from 175 companies; Dr. Stephenson's most recent survey is based on data from 174 companies.

The variance of the GAO results is best seen in the context of what statisticians refer to as a "95 percent confidence interval." As noted in the NAMES 1991 Industry Survey, 175 firms provided sufficient data from fiscal year 1990 results to calculate a profit margin as defined above. The mean value for return on sales from these 175 companies was 6.0 percent, with a standard deviation of 8.7 percent. Using standard statistical techniques yields a 95 percent confidence interval of 1.1 percent This means that there is only a 5 percent probability that the true mean return on sales (the return from all 1,844 regular NAMES members if data on all 1,844 firms were available) lies outside the interval of 6.0 percent plus or minus 1.1 percent. Stated alternately, there is a 95 percent probability that the "true" mean return on sales for all 1,844 firms lies in the interval of 4.9 to 7.1 percent. In the NAMES 1990 Industry Survey (1989 operating results), the average profit margin for 126 firms providing data was 6.4 percent, with a 95 percent confidence interval of plus or minus 1.1 percent. In the NAMES 1989 Industry Survey (1988 operating results), the average profit margin for 123 firms was 6.2 percent, with a 95 percent confidence interval of plus or minus 2.1 percent. Thus, in three separate industry surveys conducted in 3 different years, the mean profit margin based on a large sample only varied from 6.0 to 6.4 percent across the 3 years and the 95 percent confidence interval was never larger than plus or minus 2.1 percent. In round numbers, based on the industry's three independent surveys of large numbers of companies, one can be 95 percent confident that the true mean profit margin for HME firms is in the range of approximately 4 to 8 percent.

**Putting the GAO finding in context using standard statistical techniques, the probability that the GAO finding of –2 percent profitability represents the "true" mean profitability is less than one-half of 1 percent. The estimates of 19 percent profitability on Medicare business and –24 percent (loss) on non-Medicare business are even farther outside the realm of possibility. In straightforward language, there is at least a 99.5 percent chance that the GAO data are wrong.**

Confidence intervals also can be constructed for the profit margins GAO reported. Based on the data in Table 1 of the GAO Report, the arithmetic mean overall profitability (i.e., the unweighted arithmetic average) is zero, with a 95 percent confidence interval of plus or minus 10.6 percent. GAO's result tells us that its "true" mean overall profitability is somewhere between a 10.6 percent loss and a 10.6 percent profit. This confidence interval is so large because of the very small sample size employed and the wide variability around the mean. Using standard statistical tests for differences between means, the GAO-reported profitability means for Medicare and non-Medicare business are not statistically different from each other at a 95 percent confidence level. That is, it cannot be established with 95 percent confidence (the standard confidence level used in social science research) that the "true" mean profits for Medicare and non-Medicare transactions are different from each other based on the GAO results.

**The point of comparing the GAO results with independent survey results is not to argue that actual industry profitability is higher or lower than the GAO Report shows, but to emphasize that the GAO results are totally outside the range of reason based on several large-scale industry studies undertaken by qualified, independent researchers. As a policy guide, the GAO results are at best irrelevant and at worst a positive disservice both to the firms in the HME services industry and to the government policymakers that GAO serves.**

The second reason the GAO result is startling is that the profitability for Medicare versus non-Medicare business is vastly different and in the opposite direction from what a common sense analysis would expect. Since the same products are being rented or sold to Medicare and non-Medicare customers alike and non-Medicare reimbursement levels are **higher** than Medicare reimbursement levels according to nearly all suppliers in the industry, how is it possible that non-Medicare profits are **lower** than Medicare profits? Not only does GAO find that profits are higher for Medicare business, they find them higher by an enormous gap: 19 percent profits for Medicare-reimbursed business versus –24 percent loss for non-Medicare business. This simply is not possible. But the Report does not mention the differences in reimbursement levels for Medicare versus non-Medicare, so this issue is never addressed. It is small wonder that GAO "did not take the additional time that would have been needed to obtain written comments from the suppliers on a draft of this report" (p.4 of GAO Report).

**Inquiries undertaken with executives of the six audited firms reveal that the answer to the above question is actually quite simple. If non-Medicare reimbursement levels are higher than Medicare, the only possible way to calculate lower profit margin for non-Medicare reimbursed business is to design a cost accounting system that "lads" more costs against non-Medicare business than against Medicare business.**

For example, a review of the detailed spreadsheets prepared by GAO at one of the surveyed companies showed 15 products that were handled in both Medicare and non-Medicare lines. For 14 of the 15 items, non-Medicare prices were higher than Medicare prices: for these 14 items, the ratio of Medicare to non-Medicare prices ranged from 104 percent to 267 percent. Yet GAO concluded that this firm was earning a 14 percent profit on its Medicare business while losing 42 percent on its non-Medicare business. How is this possible?

The answer is deceptively simple: GAO allocated direct and indirect costs at 19.4 percent of revenue to Medicare business compared to 32.0 percent to non-Medicare business. In allocating overhead, GAO allocated overhead of 66.8 percent of revenue to Medicare but an incredible 110.2 percent of revenue to non-Medicare—this in spite of the fact that Medicare business accounted for 65 percent of this company's total business. Overall, this company's total revenue was divided 65 percent to Medicare and 35 percent to non-Medicare, while total overhead costs were allocated 53 percent to Medicare and 47 percent to non-Medicare. To accept the GAO results, one has to be willing to believe that overhead is 10.2 percent greater than revenue for non-Medicare business while 33.2 percent less than revenue for Medicare business. This assumption defines the word "incredible."

REVENUE COMPARISONS UNDER VARIOUS REIMBURSEMENT LEVELS

Other problems exist with the GAO Report in addition to the above-described sampling and accounting problems. In particular, the comparisons of the six firms' revenues under the reasonable charge methodology that was in effect prior to OBRA 1987, the OBRA 1987 fee schedule and the fee schedule as modified by OBRA 1990 present some problems. For example, GAO's projections to 1993 under OBRA 1990 guidelines do not take into account the OBRA 1990 requirement for a purchase option in the 10th month for capped rental items.

**The purchase option change is expected to have a major adverse impact on HME revenues, but GAO "assumes away" this impact with the statement that "We did not consider this change in reimbursement method in our analysis because no data exist to predict how many beneficiaries will elect the purchase option" (p. 7 of GAO Report). If this major change is not considered in estimating revenues after OBRA 1990, it should be obvious that GAO's projections to 1993 are of little or no value. Surely if Congress added this rental option requirement, there was some reasonable basis to suggest that this option would benefit patients and provide some savings to Medicare. Ignoring this change makes the projections for 1993 irrelevant.**

Since the purchase option for capped rental items is expected to reduce Medicare expenditures, one would estimate that the GAO results comparing the 1993 fee schedule to the reasonable charge method overestimate 1993 revenues by some amount. However, even without the impact of the purchase option for capped rental, the data reported in Table 2 (p. 6 of GAO Report) show that four of the six suppliers will receive revenues from the 1993 fee schedule than they would have under the old reasonable charge level. The GAO conclusion that 1993 fee schedule revenues will be "about 4 percent greater than our estimate of their 1993 revenue under the reasonable charge system" (p. 6 of GAO Report) results from the use of weighted averages and the fact that the largest supplier in the survey would have an increase of 15 percent in revenues. Revenues are projected to decrease for four of the five smaller suppliers under the 1993 fee schedule. In total, the five smaller suppliers will see revenue declines of $134,000—from $1,853,000 under the reasonable charge method to $1,719,000 under the 1993 fee schedule. The 4 percent overall increase reported by GAO results from the fact that the largest firm, which is nearly three times larger than the next largest firm on the list and over 10 times larger than the smallest firm on the list, is projected to experience a 15 percent increase in revenues. **In short, the projected overall increase in revenues results primarily from the projections for one branch of one large firm—hardly representative of the industry in general.**

Finally, the Report offers virtually no comment on the rather startling changes in profit margins estimated by GAO based on the 1989 reasonable charge method as compared to the 1989 and 1993 fee schedules reported in Table 3 (p. 7 of GAO Report). In Table 1 (p.4 of GAO Report), GAO reports that "annualized" 1988 prof-

its, under the existing fee schedule in effect in 1988, were 19 percent for Medicare business. In constructing Table 3, GAO estimates supplier profits for 1989 using the reasonable charge rates that would have been in effect had the fee schedule not been implemented and then estimates profits under the 1989 and 1993 fee schedules. Profits for the 1989 reasonable charge method are estimated at 31 percent, an increase of over 61 percent from the results reported for "annualized" 1988. How such a huge increase could have possibly occurred is left to the reader to guess. Then, under the 1989 fee schedule, profits are reported in Table 3 at 45 percent, an increase of 136 percent over "annualized" 1988 levels. Since the 1989 fee schedule is roughly comparable to the 1988 fee schedule (this is the OBRA 1987 schedule and both years are prior to the OBRA 1990 changes), one is left wondering how such a radical change could occur. The Report is silent as to how the same six suppliers, operating under generally similar reimbursement guidelines, could experience such a radical change. It seems highly likely that such a change must be due to errors in the data.

CONCLUSION

In conclusion, the GAO Report offers little evidence on which to base future Medicare coverage and payment policy. The sample size is too small and undiversified to offer any insights into a $1.4 billion program. Reliance on unaudited financial statements for short periods of time (one-to-four months), which are then extrapolated to produce "annualized" results, makes the value of any such results highly suspect. In addition, the inability of GAO to make any estimate of the impact of the purchase option for capped rental items undermines any possible estimate of the revenue impact of OBRA 1990 on HME suppliers.

GAO concluded that "Changes to the fee schedule enacted in OBRA 1990 removed some of the revenue gains, and we estimate that the suppliers included in our analysis will experience an aggregate increase of 4 percent over the reasonable charge reimbursement rates when the OBRA 1990 changes are fully implemented in 1993" (p. 9 of GAO Report). Based on the data presented, it would be much more accurate to conclude that, although GAO is unable to estimate the decrease in revenues as a result of the new purchase option requirement for capped rental items introduced by OBRA 1990, four of six suppliers in the study will experience revenue decreases compared to the reasonable charge reimbursement rates when the OBRA 1990 changes are fully implemented. When the results of the purchase option are known, the four suppliers projected to experience revenue decreases will experience decreases greater than currently projected, and the two suppliers projected to experience increases may or may not see such increases come to pass.

**Finally, as a policy guide, the GAO results are at best irrelevant and at worst a positive disservice to the entire HME services industry and government policymakers that GAO serves.**

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STATEMENT OF THE GOLDEN RULE INSURANCE COMPANY

All too often commentary focuses on solutions and technical aspects, as opposed to identifying problems.

The problem small businesses face in obtaining and keeping insurance is affordability. Study after study has pointed to the cost of health insurance as the reason small businesses do not have health insurance. The Congressional Budget Office is but one of many respected organizations to report this; in its April 1991 study, the CBO stated that "86 percent of the employers not offering insurance to their employees cited high premium cost as the reason." The Academy of Actuaries stated in its issues Digest 1991: "The current problem is not one of access to health insurance; in fact relatively few people are uninsurable at any time. The problem is affordability. Health insurance is expensive because health care is expensive. Creating larger pools or pooling groups with different risks cannot reduce the average cost."

Because people are uninsured because they cannot afford health insurance, Golden Rule strongly supports S. 1872's proposal to make health insurance fully tax deductible for the self-employed.

In fact, we strongly support full national tax equalization. All Americans should receive the same tax treatment for health insurance costs. There can be no defense of the current system which gives the biggest tax advantage to the wealthiest individuals with the richest plans (e.g., highly paid executives of rich corporations) while so many low income people go without insurance because they must pay for their health insurance with after-tax dollars.

Golden Rule may be the best qualified company to speak to this issue. We are the largest commercial insurer of health insurance for individuals in the country.

Many of our insurers pay for their health insurance with after tax dollars. For example, we just completed a survey of our insureds in Vermont: 54 percent earn less than $25,000 per year, and 33 percent earn less than $15,000 per year. Not only would insurance become much more affordable for these people if the cost were tax deductible, but we could also reach many of the presently uninsured. Indeed, Citizens for Affordable Health Insurance estimates that we could reduce the ranks of the uninsured population by 10 million people simply by making the cost of health insurance fully tax deductible for everyone.

Golden Rule also supports S. 1872's requirements that small group health insurance be collectively renewable. We already conduct business this way for all of our health insurance lines. People who buy our health insurance are pooled with many other people, and the cost of their health insurance is reflected in equitable premiums for all.

This eliminates the concern that small employers have for being singled out for termination if someone in the group develops an expensive medical condition. Although this fear may be overstated—there is no evidence documenting the scope of this problem, only anecdotal information—no reputable insurance company can object to this provision.

Employers also state a concern that, in the absence of an outright termination, they may be subjected to abusive rate increases. S. 1872 deals with this problem by establishing rate bands and limiting annual rate increases for in-force business.

This is the correct way to solve this problem, but it is also possible to produce unintended consequences from rate restrictions that are too narrow. Specifically, the segment of business which produces the highest claim cost requires the highest rates. These rates become the upper end of the allowable rate bands (the "ceiling" rate). The lowest permissible rate (the "floor" or new business rate) becomes a slave to the ceiling rate.

Thus, a carrier with large amounts of older, higher claim cost business will find itself in a precarious position: if it charges enough to its mature business, its new business rate may be uncompetitive. But if it attempts to remain competitive with its new-business rates, it will almost certainly lose money on its more mature business.

The consequence may be that S. 1872 penalizes the carriers that have been in the business the longest and have the largest shares of market, while creating a competitive advantage for newer (possibly less experienced) carriers.

Furthermore, since the "ceiling" rate drives the "floor" rate, the more narrow the rate bands and the more restrictive the permissible rate increased, the higher will the "floor" or new business rates available in the market become. Since affordability is the central issue, S. 1872 will make insurance even more expensive for small businesses trying to get into the system. Marginal small businesses may find themselves unable to keep insurance.

A primary reason for this is that we have a voluntary system of insurance in this country. Unless we are prepared to compel people to buy insurance, narrow rate bands will drive health insurance premiums out of reach for an increasing number of people.

Therefore, Golden Rule strongly recommends that the rate restrictions more closely parallel those spelled out in the NAJC's Small Group Premium rates and Renewability Model Law. This will promote fairness without causing needlessly high rates.

The voluntary nature of the small group health insurance market is also the fundamental reason why S. 1872's proposals to restrict underwriting will result in substantial increases in premiums costs to small businesses. Golden Rule Insurance Company is therefore opposed to this provision of the bill.

As cited earlier, affordability, not availability, is the reason why people are uninsured.

There is no evidence, no proof, no objective studies that can be cited to show that the underwriting practices of the insurance industry are a major source of the uninsured problem.

The truth is that underwriting makes it possible for people without insurance to find affordable health insurance in the market place. If we take away the incentive to purchase health insurance while one is healthy and replace it with an incentive to postpone the purchase of insurance until one needs it, we will drive healthy people from the system and replace them with unhealthy people. The result will be higher claim costs and higher premiums for those remaining in the system.

This is not to say that we are insensitive to the needs of the truly uninsurable. While only 1 percent of our non-elderly population is both uninsured *and* uninsurable, their medical costs are far greater than for most of us.

The question is not whether we should pay for the costs of medical care for the uninsurable, but who should pay. By confining this problem to small employer groups, you are confining the cost to a relatively narrow segment of society.

The way to deal with the problem of the uninsurable is through broadly funded High Risk Pools. Many States have already established such pools, and several (Illinois, Colorado, Maine, and Oregon, to name a few) have guaranteed that all residents will help pay for these costs.

If S. 1872 were enacted as written how much higher will premiums rise for small businesses?

Based on our actual experience of writing guaranteed issue health insurance for smaller groups (10 to 25 employees) in the early-and mid-80's, the claim cost will be in excess of 50 percent greater.

Everyone who is knowledgeable on this subject agrees with our assessments.

They include respected insurance companies, the American Academy of Actuaries, Blue Cross organizations, actuarial consulting companies, and other observers, like Forbes magazine. I have attached their remarks to this testimony.

The most instructive lesson comes from recent experience in Ohio. State legislators (who no doubt believed they were proposing good reforms) introduced "guaranteed access" legislation, similar to S. 1872. They believed that this would significantly reduce the 1.2 million Ohioans without insurance because the incremental costs would be very small.

Because concern about the cost and benefits surfaced soon after introduction, the Senate sponsor commissioned an independent actuarial study. This group estimated that premiums would rise 10 percent for the small businesses of Ohio.

Blue Cross and Blue Shield of Ohio stated that this "overall increase would mean small employees would pay about $250 million more for health insurance, with little reduction in the ranks to show for it."

John Polk, the executive director of the Council of Smaller Enterprises in Cleveland stated: "The net result of enacting HIAA's program would be an unvoted tax on Ohio's small companies which would amount to hundreds of millions of dollars during a recession, for which they and Ohio's uninsured would receive almost no value."

Jim Parker testified on behalf of Community Mutual (the Cincinnati-based Blue Cross organization) that an actuarial consulting firm it hired estimated the cost increase at 21%. At that level, the net result would actually be more, rather than fewer, uninsured Ohioans.

S. 1872 will result in significantly higher premiums for small businesses. You must be honest with small businesses and tell them this.

You must also exclude health insurance that is not designed, advertised or administered as small employer group health insurance. A great many small employers do not provide health insurance to their employees but facilitate its purchase through payroll deduction. Also, many employers who do provide group health insurance do not pay for the cost of the dependents' health insurance; as a result these dependents can often find other insurance that is less expensive and better suited to their needs. it is critical that people in these kinds of circumstances are able to find products in the marketplace.

In fact, individual insurance needs to be expressly excluded from regulation as small-employer group insurance, even if it is purchased by a self-employed person or employee of a small employer.

Additionally, we recommend that you modify your small group market reforms with a four-part model law recently adopted by the American Legislative Exchange Council, endorsed by National Association of Life Companies, and introduced in several States during the current sessions. The entire bill is attached with a summary of its basic provisions.

Attachments.

The Columbus Dispatch
**Wednesday**
*JANUARY 15, 1992* ■

# Insurance bill costly, ineffective, report says

**By Mary Yost**
*Dispatch Statehouse Reporter*

Health care changes backed by Gov. George V. Voinovich would increase insurance costs for small businesses by up to 12 percent and make hardly a dent in reducing the number of uninsured Ohioans, legislators were told yesterday.

Cleveland attorney Ken Seminatore, a lobbyist for Blue Cross and Blue Shield of Ohio, announced those findings from an actuarial study. He apparently stunned the two lawmakers who initiated the study.

"That's nice they would give you the report. I haven't seen it," said Rep. Wayne Jones, D-Cuyahoga Falls, one of the legislators who sought the study.

Sen. Robert Ney, R-Barnesville, later produced a copy of the report, but his aide, Tom Strussion, said Ney had not had a chance to discuss it with the author, Tim Harrington of the American Academy of Actuaries.


Ney

Jones and Ney asked the independent group in December to look at provisions in Senate Bill 240, introduced by Ney, and analyze its impact on insurance costs.

The governor has announced support for Ney's bill as meaningful health care reform. Jones has similar provisions in House Bill 478, which is expected to be voted out of the House Select Committee on Health Care Reform next Wednesday.

Both bills aim to open access to insurance for small employers and individuals through measures such as limiting exclusions for pre-existing conditions, guaranteeing renewability and changing insurance rating practices.

Seminatore, the lobbyist, cited the actuarial study before the House Select Committee to criticize small employers' insurance provisions in Jones' bill. Seminatore said the actuaries found the overall increased cost would be about 10 percent but that some employers could see insurance premiums rise much higher. He said his law firm's costs would go up 30 percent.

The 8- to 12-percent overall increase would mean small employers would pay about $250 million more for health insurance, with little reduction in the ranks of the uninsured to show for it, Seminatore said.

The study said Ney's bill would "result in no significant change in the total number of uninsured in Ohio." An estimated 1.2 million Ohioans have no insurance. Most are the so-called "working poor," who make too much to qualify for Medicaid but cannot afford insurance.

Seminatore said Blue Cross, which insures 2 million Ohioans, supports some of Jones' bill but opposes mandatory coverage for preventive care for children in family plans and for mammography screenings in all plans.

Proponents of a Canadian-style tax-paid system, Universal Health Insurance for Ohio, also known as UHIO, criticized Jones' bill as doing little to make insurance affordable.

There were hints yesterday that the UHIO coalition of labor, retirees and religious groups is faltering.

John Hodges, president of the Ohio AFL-CIO, said he will testify next week in support of some provisions in Jones' bill as a "doable" alternative to the UHIO proposal spelled out in House Bill 175, sponsored by Rep. Robert Hagan, D-Youngstown.

The Columbus Dispatch
**Sunday**
*JANUARY 19, 1992*

# Ohio lawmakers are expected to revamp health care reform bill

By Mary Voet
*Dispatch Statehouse Reporter*

A fast-moving health care reform bill will be reigned back a little this week while proponents rethink provisions that came under attack last week.

House Bill 478 was to be voted out of the House Select Committee on Health Care Reform on Wednesday.

But more testimony is expected, and amendments are to be offered. A committee vote is tentatively set for the following week.

Administration officials are among those taking a hard look at the bill, sponsored by Rep. Wayne Jones, D-Cuyahoga Falls, in light of reports last week that some of its provisions would be much costlier and far less effective than proponents had hoped.

The committee heard that the bill could increase health insurance premiums up to 21 percent for small employers, causing some of them to drop coverage and put their employees among the ranks of the 1.2 million Ohioans who are uninsured.

Jones' bill is supposed to make health insurance more attractive to small employers. The Health Insurance Association of America is generally credited with developing the provisions.

The provisions include guaranteed access to and renewability of insurance, limited restrictions for covering those with pre-existing conditions and limits on annual rate increases.

The small-employer provisions are similar to those in Senate Bill 240, which has the support of Gov. George V. Voinovich. It is pending in the Senate.

The governor endorsed the Senate bill in a November news conference with its sponsor, Sen. Robert Ney, R-Barnesville. Voinovich said then he was waiting for results of an independent actuarial study to "make a final determination on the acceptability" of plans to pay for the small-employer reforms through a premium surcharge.

At the time, the measures were estimated to increase the cost of health insurance to small employers by 2 to 9 percent. The independent actuarial study came up with cost increase figures of 8 to 12 percent.

Also, an actuary hired by Community Mutual estimated the increase at 21 percent, testified Jim Parker, a lobbyist for Cincinnati-based Blue Cross.

Both studies said the provisions would not reduce the numbers of uninsured Ohioans.

David Randall, deputy director for the Department of Insurance, said he will testify Wednesday for the administration.

The Columbus Dispatch
**Thursday**
*JANUARY 23, 1992*

# Coverage provision might be dropped from health bill

**By Mary Yost**
*Dispatch Statehouse Reporter*

A major provision of a health care reform bill moving through the House of Representatives is likely to be yanked because of strong objections by the small employers the legislation was designed to help.

Rep. Wayne Jones, D-Cuyahoga Falls, said yesterday he and other lawmakers may eliminate provisions in House Bill 478 that would require insurance companies to offer coverage to small employers who seek it.

Representatives of small employers testified before the House Select Committee on Health Care Reform yesterday that the "guaranteed issue" provision would drive costs up too much and have little benefit to an estimated 1.2 million uninsured Ohioans.

Jones said the provision was aimed at helping prevent small employers from being rejected for insurance coverage. He added, "I'm not going to force-feed them."

Meanwhile, Jones' bill gained support yesterday from the Voinovich administration. Testifying in favor of the bill, with some changes, were the directors of the departments of health and aging and a deputy director of insurance.

In November, Gov. George V. Voinovich endorsed a Republican-backed bill with similar provisions, Senate Bill 240, and hardly mentioned Jones' bill. The Senate bill is pending in a committee. Jones' bill is expected to be moved out of committee and could be approved by the House next week.

Rep. Barney Quilter, D-Toledo, chairman of the select committee, said he expects to consider amendments and call for a vote Tuesday. Quilter said House Speaker Vernal G. Riffe Jr., D-Wheelersburg, has said he wants to send the bill to the Senate this month.

The Health Insurance Association of America drafted most of the small employer health care provisions in both Jones' bill and the Senate bill, sponsored by Sen. Robert Ney, R-Barnesville.

A provision would impose a surcharge on current policies to help pay the increased cost of offering insurance to any employer who wants it.

"The net result of enacting HIAA's program would be an unvoted tax on Ohio's small companies which would amount to hundreds of millions of dollars during a recession, for which they and Ohio's uninsured would receive almost no value," said John J. Polk, executive director of the Council of Smaller Enterprises in Cleveland.

"We would endorse guaranteed issue (of coverage) if the proposal contained strong cost-control features. The decoupling of access and cost is ill-advised and would lead us to solving one problem by creating others," said Eric Burkland, president of the Ohio Manufacturers' Association.

Burkland also testified on behalf of the Ohio Council of Retail Merchants, the Ohio Farm Bureau Federation, the National Federation of Independent Business/Ohio and the Small Business Council of the Ohio Chamber of Commerce.

Burkland said he wanted to send a message that health care providers cannot resist change much longer.

"Today there are just five of us here together. Next time, there will be many, many more of us," he said. "The provider community seems to be assuming a world of unfettered choice and unlimited resources, while ... our members are fighting for their economic lives in a global economy of radically changed circumstances.

"The days of complacent prosperity are gone forever."

Probe

Vol. 38, No. 7 April 15, 1991

# A Minority of One

*by Arthur V. Ferrara, CLU*

A recent resolution of the HIAA Board of Directors, if enacted into law by enough state legislatures, could destroy both the affordability and accessibility of group health insurance for businesses employing 3 to 25 employees. In a well-meaning attempt to solve a universally recognized problem, the HIAA has succeeded only in exacerbating that problem. The HIAA program will:

- accelerate the already alarming upward trend of health rates;
- force many small to medium-sized insurance companies to abandon this market;
- cause many small employers to terminate their existing group health policies as financially unmanageable.

At present there are between 31 and 37 million Americans who have no health insurance protection. Many are workers or dependents of workers. Why don't these people have health insurance? Usually for one of two basic reasons:

- It's not affordable.
- It's not accessible.

Not accessible includes situations where their employer doesn't offer it, or they can't qualify because of past or present health problems. As a result of this lack of insurance, many of these people do not have access to proper medical care.

The HIAA proposes to solve this problem by recommending to all state legislatures and insurance commissioners the adoption of the following proposal:

All employers with 3 to 25 employees will be guaranteed the issuance of group medical insurance policies regardless of the condition of health of any of the employees or their eligible dependents. The insurance companies underwriting these policies may request evidence of insurability on all these employees and dependents. Based on their findings they can make weighted charges to the uninsurable and impaired risks that make application for insurance.

The insurers can, in turn, cede these risks to a reinsurance company or pool that will be established to reinsure these impaired risks. The losses incurred by the reinsurance entity will be charged back to small employers to cover the additional claims incurred by the uninsurables. A cap of a 5% chargeback is to be incorporated to control the assessments made on small employers. If this 5% is inadequate—as it most certainly will be—the HIAA proposal is nonspecific as to the source of any participating insurer deficiencies.

It seems to me that this overly simplistic, unworkable arrangement has two great advantages.

**Advantage #1:** It takes society's problem, namely, the uninsurable, and conveniently transfers that problem to the small employers in the United States, and, in turn, to the companies insuring those small employers.

**Advantage #2:** This arrangement retains the status quo for all employers with 25 or more employees (including the Fortune 500 companies). At the same time, it does not require the mega-companies who insure these large employers to participate in any meaningful way in the risk imposed by this solution.

On the other hand, I can see a number of serious disadvantages were this plan adopted.

**Disadvantage #1:** It abandons a fundamental principle of all sound insurance arrangements—risk selection.

**Disadvantage #2:** The additional cost burden imposed by covering uninsurables could make the premium unaffordable for many small employers and their employees who are presently insured. We could actually end up with more people uninsured than we now have.

**Disadvantage #3:** There is no clear, acceptable solution for the very real possibility that a 5% surcharge on small employer premium will be inadequate to fund the reinsurance pool.

**Disadvantage #4:** There is no clear, acceptable solution in the event of bankruptcy of the reinsurance pool.

**Disadvantage #5:** Experience has clearly shown that high insurance rates drive the healthy out of the fully-insured market, leaving only the groups with serious health problems.

**Disadvantage #6:** Many small to medium-sized insurance companies currently in the small group market might be forced to abandon the sale of group health insurance. The potential downside risk to these companies could represent a serious threat to their financial stability in other markets.

(It is important to note here that these very companies are the backbone of the small employer group health insurance market. Not one of the five largest group health insurers is a significant player in this marketplace. They have already virtually abandoned this part of the market as inherently unprofitable, even before the HIAA would strip us of the protection of risk selection.)

**Disadvantage #7:** The HIAA proposal would require one segment of our citizens (small employers and their employees) to bear the expense of solving what is truly everyone's problem. This is essentially unfair and unworkable.

As CEO of a mutual insurance company that is one of the largest underwriters of small groups, I feel obligated to take a strong stand against this HIAA proposal. I believe that it is not in the best interests of our present and future policyholders. An insurance company such as The Guardian can take on more of a health insurance risk by insuring a five-life group in New York City than a Met, or a Pru, or a Travelers, or an Aetna or a CIGNA takes on by insuring any one of the Fortune 500 companies.

As a member of the HIAA Board of Directors, I have voiced my opposition to the organization's stand on this crucial issue. Other, more viable solutions are available to us. Finally, as a concerned proponent of the viability of small businesses, I encourage all those who are interested in finding pragmatic, fair solutions to the problem of making affordable healthcare insurance available to small employers, to join with this "David" in opposing the insurance "Goliaths" in every state in which they promote this plan.

I also encourage you to join with us in fighting to abolish the many unfair practices and abuses that some insurance companies have visited on this share of the market. These abuses include, but are not limited to:

- Discriminatory renewal rating practices,
- Tier rating,
- Arbitrary policy cancellations due to large or frequent claims.

These practices have been a significant contributing factor to the problem of the availability of health insurance coverage to small groups. Ending them should go a long way to solving this problem.

If that is not enough, then let's discuss a pool that's financed by all employers—large and small, insured or self-insured. The financing mechanism could be based on a small percentage of medical expenses reimbursed, regardless of the source. If this social problem can't be handled by local, state or federal governments, then at least we must assure that the burden be distributed over the largest possible financial base.

Equitable distribution of this burden was not a high priority of the Board. The larger companies exercise a commanding position on HIAA committees and its Board. Concerned over the specter of national health insurance, they convinced the Board to adopt a poorly conceived plan which will exacerbate rather than solve the problems of availability and affordability of health insurance. The cost of the proposal will not affect those large companies and their policyholders. They are not significantly involved in the small employer group market, and are apparently not involved in the cost of the solution proposed.

Small businessmen and their employees who are so important to the economy of the nation, and are already burdened with costs of taxation and regulation, will again be asked to solve the problem.

*Arthur V. Ferrara is president and chief executive officer of The Guardian.*

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# Unintended consequences

THERE'S A DOWNSIDE to proposals to reform health insurance policies sold to businesses with fewer than 25 employees. The reforms, which have to be approved by state legislatures, could increase the premiums for perhaps four in ten small businesses.

Insurers have been swamped by criticism from small businesses about the way rates can now double when one employee gets seriously sick. The National Association of Insurance Commissioners, Blue Cross and the for-profit health insurers have all proposed limiting how much extra an insurer can charge to small companies with ailing workers. How would this be financed? Through relatively higher premiums for small companies with healthy workers.

The increases for the healthy groups could be substantial. One actuary who has analyzed the proposed reforms says the increased premiums "could be as much as 35% in a few cases, and 15% to 20% increases would be common." Typically, a business employing, say, 20 reasonably healthy workers could find an extra $12,000 a year tacked onto a $60,000-a-year health insurance bill.

One aim of reform is to spread the availability of health insurance to the 9 million workers in small firms who currently don't have it. Health insurers would be forced to take on even the sickest groups, which in some areas can't now get coverage at any cost. The insurers could then palm off the very worst risks into a pool whose losses would be financed by a surcharge on the premiums charged all small businesses. But some reformers fret that the proposals could in the end swell the ranks of the uninsured because three times as many businesses would see a premium increase as a decrease. The fact is that the vast majority of uninsured small businesses haven't been turned down for health insurance for medical reasons; they simply can't afford to pay the premiums. –JANET NOVACK

# The Actuarial Update

VOLUME 20 NUMBER 7 AMERICAN ACADEMY OF ACTUARIES


## In this issue



### Enclosures

Included in this month's issue of *The Update* are the following:

- Government Relations Watch
- In Search Of . . .
- ASB Boxscore
- Committee Service Volunteer Card

## Health Committee Testifies on Small Group Reform

by Gary D. Hendricks

Many small employers don't provide health insurance because they can't afford it, and limiting underwriting in the small-group health insurance market will make coverage even more expensive. Harry Sutton, vice chairperson of the Academy's Committee on Health, echoed these themes when he presented the committee's written testimony to the Ways and Means Subcommittee on Health, May 2.

### Ways and Means Subcommittee

Sutton told the congressional subcommittee, "The reason we have frequent changing of carriers and the various rating systems used for small group health is because most small employers can't afford health insurance. But some of them, if they are underwritten carefully, can get lower rates."

To underscore the problem of affordability, Sutton pointed out that, by one estimate, large employers are now paying $4,100 per employee for health insurance. For many smaller employers and their workers this rate, or even a lower one, may be just too high. Moreover, "small employers very often pay a minimal amount, such as half of the single-employee premium, and the employees have to cover their dependents." He reflected, "Not surprisingly, many decide *not* to cover their dependents because the cost is too high compared to their incomes."

Sutton told the subcommittee, "The reforms you are talking about in the small group market—limiting underwriting, limiting pre-existing condition exclusions, and moving toward community rating—will raise the average premium for many of the small employers who already buy coverage." This point, discussed at length in the committee's written testimony, was readily agreed to by the other expert witnesses at the May 2 hearing, General Accounting Office representatives and Lynn Etheredge, a health policy consultant and former head of professional staff for the Office of Management and Budget.

Sutton also emphasized the importance of making coverage as affordable as possible and outlined a few things that would help. "First, get rid of all the state mandates and permit low-option benefit plans," he said. In addition, "we need an emphasis on managed care; any legislation should prevent states from limiting the use of managed-care or provider networks and should encourage the development of HMOs."

*(continued on page 4)*

## NAIC Action on Appointed Actuary

by Gary D. Simms

The Casualty Actuarial (Technical) Task Force of the National Association of Insurance Commissioners (NAIC) has adopted a recommendation for the creation of an "appointed actuary" to issue statements of opinion related to loss and loss adjustment expense reserves for property and casualty insurers.

The recommendation, adopted at the June 1991 Summer National Meeting of the NAIC, will be forwarded to the NAIC's Blanks (EX4) Task Force in October for implementation in connection with the 1992 annual statement.

The proposal parallels action on the life side now underway concerning the valuation actuary concept. The Casualty Task Force proposal would require that a qualified actuary be appointed by the insurer's board of directors by December 31 of the calendar year for which the opinion is rendered. When-

*(continued on page 4)*

PERSPECTIVE ON SMALL GROUP MARKET REFORM

Community Mutual Insurance Co.

Blue Cross Blue Shield
37 W. Broad Street
Columbus, OH 43215

September 1991

Employer Impact

Employers with high risk employees would certainly notice improved access to coverage if the changes advocated by the HIAA were adopted. Other employers would not notice any change in their access to insurance coverage. However, all employers would see noticeable increases in the premiums they are charged for coverage. A study of the proposal by Community Mutual estimates that immediate premium increases of 20-25% can be expected. (See Attachment B. Community Mutual has commissioned an outside actuarial firm to do an independent study of the proposal to confirm these figures.) Another study performed by Orion Consulting and commissioned by Blue Cross and Blue Shield of Ohio concluded that premiums could increase up to 20%.

In today's small group insurance market, there are two overriding reasons why employees do not have coverage: either it is unaffordable at today's prices, or it is unavailable to high risk individuals and groups at any price. The HIAA proposal will make coverage available to those who cannot purchase coverage today for health reasons. It may also be equally successful in making insurance even more unaffordable for those without existing health conditions.

# II. Insuring the Nation's Health Care Needs

Three issues have dominated the federal health policy arena over the past year: providing the uninsured population access to health care, implementing physician reimbursement reform for Medicare, and beginning the search for new solutions to our nation's needs for long-term care.

Two primary factors have accounted for the current focus on health insurance reform. During the 1980s, there was a dramatic increase in the number of uninsured. In 1980, the Bureau of Census estimated that 29.9 million Americans were without health insurance coverage from any source, including public programs such as Medicare and Medicaid. By 1987, that estimate had increased to 37.4 million, a 25% increase in just seven years.

Health care inflation, like the number of uninsured, also soared during the 1980s. Between 1951 and 1980, the Consumer Price Index (CPI) for all goods and services rose an average of 4.2% a year, while medical costs increased at a somewhat higher rate, averaging 5.5% annually. Compare that to the decade of the '80s, when the CPI rose 4.7% a year, and medical costs shot ahead to an annual rate of 8.1%.

After forty years of medical costs rising more rapidly than other prices, many employers and individuals were finding the cost of health insurance prohibitive. In 1965, employer-provided health benefits were equivalent to 14% of after-tax profits. By 1984, this figure had risen to 74%, and six years later, in 1990, employer-provided health benefits equaled 90% of after-tax profits.

Costs, which have been important in stimulating the broader health debate, have been the overriding factor driving Medicare policy. Throughout the 1980s, each year's budget bill has included a new list of provisions to reduce Medicare costs. Although hospital reforms enacted in 1983 appear to have met with some success, reimbursements to physicians continue to grow uncontrolled. An effort by the Health Care Financing Administration (HCFA) to begin to restrain that growth through the implementation of recently enacted reform has become the focus of new congressional controversy.

Although not in the forefront of the current debate, long-term care continues to be an issue with which Congress struggles. Here again, cost is a major concern. On average, one year in a skilled nursing facility costs from $25,000 to $35,000. Home health care is costly as well. Three home health aid visits (unskilled care) per week can cost $6,500 annually. Three skilled care visits a week can cost $10,000 annually. Ten years from now these costs will likely double.

Long-term care can be needed at any age. However, the need is most evident among the nation's aged, where simply living longer increases the likelihood that frailties and chronic maladies will intrude. Over the next thirty years, the U.S. population age 65 and older is projected to increase by over 50%, and the population age 85 and older is projected to triple, even though the total population is projected to remain almost stable. Population aging alone will make long-term care a continuing national policy concern.

One final trend in health regulation must be noted. In the past, Congress has left the business of regulating private insurance products largely to the states. This now appears to be changing. In 1990, Congress enacted extensive new federal standards for Medicare supplemental insurance (Medigap) plans. Congress is now contemplating federal standards for long-term care policies. If this is a new trend, insurers may increasingly see federal standards that are state administered and enforced.

## The Uninsured: Searching for a Solution

**Requiring Employer-Sponsored Coverage.** The current health insurance debate began in early 1987 when Senator Kennedy (D-Massachusetts), a longtime proponent of national health insurance, introduced his "mandated benefits bill." This bill was designed to provide near-universal health insurance coverage for Americans under age 65. The proposal would have preempted state-mandated benefits and replaced them with a federally mandated minimum benefit package that most employers would have been required to provide.

To insure the availability of health insurance and to build on the current private system, the bill would have established regional pools of insurance providers for which private insurers could bid for entry. Employers could self-insure, or they could purchase insurance from one of the regional carriers. To provide flexibility, employers would have had the option of providing benefits actuarially equivalent to those in Kennedy's minimum mandated benefits package. Actuarial equivalence would be certified by a member of the American Academy of Actuaries.

The move toward universal coverage never got off the ground in the 100th Congress. Nearly every interest group opposed Kennedy's mandated approach. The Reagan administration was staunchly opposed to employer mandates; small businesses feared the cost; big business was already providing health insurance and viewed Kennedy's "minimum" benefits as too expansive; and the major unions were concerned that employers would use Kennedy's package as a rationale for decreasing current benefits.

With so little support for Kennedy's mandated benefits approach and no other options on the table, the health insurance debate of the late 1980s could have quietly disappeared. No large vocal bloc of voters was demanding that something be done, and anything that would financially help a significant number of the uninsured was highly controversial.

Surprisingly, the debate did not die.

**The Pepper Commission.** During the 100th Congress, a number of studies were begun to explore alternatives. The Pepper Commission, a bipartisan group of members of Congress and presidential appointees, conducted the most publicized study. In its September 1990 final report, the commission recommended that all businesses with more than 100 employees be required either to provide health insurance or to contribute to a public plan for their employees and nonworking dependents. The minimum benefit package would include primary and preventive care, and physician and hospital care. Tax credits would offset health insurance costs for certain small employers, and the self-employed would receive full deductibility of premiums.

In addition, the Pepper Commission proposed prohibiting medical underwriting in private insurance and eliminating exclusions for preexisting conditions—practices many in Congress believed were reducing affordable access to health insurance. Medigap reforms were also proposed, as were extensive changes to Medicaid and a national program for long-term care.

The final outcome of the Pepper Commission disappointed many who supported health care reform. The commission could not reach agreement on how to finance its proposed reforms and was seriously split along partisan lines on many other issues.

**Current Proposals and Approaches.** Too many Americans lack financial access to insurance. During 1991, the first session of the current Congress, over a dozen bills have been introduced that would ensure near-universal access to health care. The approaches proposed include:

- ❑ expanding Medicaid to cover large segments of the currently uninsured;
- ❑ covering the entire U.S. population under Medicare, and limiting private insurance to supplemental coverages;
- ❑ requiring the states to establish their own individual programs to cover the uninsured within the state; and
- ❑ mandating employer-provided coverage, and covering others through an existing or new public program.

Many of the bills would expand tax incentives for non-incorporated businesses and preempt state-mandated benefits. Others would encourage expan-

sion of multiple employer trusts and establish Medicaid buy-in arrangements.

After extensive hearings, Congress has, for the moment, narrowed the range of options. All proposals currently under serious discussion build on the nation's existing private, employer-based system and have a "play-or-pay" provision as a key element. These provisions require employers to provide health insurance for their employees or pay an additional tax. All proposals replace state mandates with federal minimums, and all would alter the marketing of private health insurance by prohibiting many current underwriting practices.

The most recently introduced bill of the mandated-benefits/play-or-pay genre is S.1227, "Health America: Affordable Health Care for All Americans Act." The Democratic leadership in the Senate developed this bill. Senate Majority Leader Mitchell (D-Maine) is the principal sponsor of the bill, and its cosponsors include Senators Kennedy, Riegle, and Rockefeller.

**The Prognosis for Near-Term Reform.** The Senate Democratic leadership's bill will undoubtedly be the springboard for many Senate hearings over the next year. However, there is considerable doubt whether the bill will become a centerpiece for consensus and compromise.

The House Democratic leadership has yet to introduce a bill. If the House Democratic bill parallels the Senate Democratic bill, then it is possible that the Senate bill will be central in any major reform during the next three to four years. On the other hand, if the House Democrats reject the employer-based system and, instead, propose a national public program, then any broad-based reform seems doubtful.

Even with consensus among the Democrats, the chances may still be remote for enactment of extensive changes like those proposed in S.1227. Only two days before the bill's introduction, President Bush stated publicly that his administration would resist mandated benefits programs in all areas, including federally mandated national health care. The President's public statements indicate that any administration proposal would rely heavily on the states, would not require employer coverage, would focus on reducing certain costs (such as the cost of malpractice insurance and private-sector administrative costs), and might limit state mandates in some areas. Regarding private insurance, the administration might prohibit certain rating and underwriting practices, especially in the small-group market.

In any case, no major Republican proposals are expected to be introduced this year. The Republican leadership in Congress has said there will be a Republican bill in 1992. An administration proposal, however, may not be forthcoming until the 1992 election campaign begins.

Ultimately, major change in the nation's health policy will depend upon how concerned middle-class Americans become with reduced benefits from their employers or whether they will be willing to take jobs where health insurance is not provided. And it will depend on how many states will soon enact programs to expand coverage. It will also depend upon how strongly businesses, large and small, resist the changes most favored by Congress. Finally, Republicans and Democrats will have to agree on some middle ground acceptable to voters.

**Incremental Reform.** Although the prospect for near-term comprehensive reform is remote, change seems inevitable. If change is to be incremental, then broad-ranging proposals such as the Pepper Commission's and the Senate Democratic leadership's bill deserve careful study. Individual pieces of these proposals are likely to become the guidelines for piecemeal change. In fact, it is probably fair to say that an incremental approach is already taking shape.

The Pepper plan has already achieved a level of success. As part of the Omnibus Budget and Reconciliation Act of 1990 (OBRA 1990), Congress implemented three measures proposed by the commission. The budget act established extensive new federal standards for Medigap policies, guaranteed access to public insurance for all pregnant mothers and children below the poverty line, and began the first phase of the commission's long-term care plan by providing more home care services through Medicaid. Federal standards for private long-term care insurance now seem likely. Underwriting restrictions for employer-provided insurance in the small-group market are included in the major comprehen-

sive reform bills, and Congress could decide to enact these provisions independent of comprehensive reform.

Thus, the likely result of failure to achieve a political consensus for broad health-policy changes may well mean a series of annual smaller changes. These could slowly improve the system over time, or they could prove disruptive and tend to undermine the current private group insurance system for the nonaged working population and their dependents. One simply has to look at the private pension system to see just how disruptive continual congressional tampering can be.

**Actuarial Involvement.** Although greatly expanded insurance coverage is a goal all can share, accomplishing this objective is difficult within the context of a mixed public and private insurance system. Poorly designed combinations of expanded public programs and more restrictive rules for private insurance can create opportunities for individuals to opt for coverage only when they need it and, thus, avoid paying their share of the real cost of insurance. Programs can also create opportunities for employers to make choices that shift costs to others within the system.

Cost containment is also a serious concern. Aggregate health care expenditures could increase substantially because of induced utilization or the coverage of medical services that legislators inadvertently failed to exclude. Poorly designed programs also can lead to costs being inequitably distributed in ways not intended. Health care costs have reached such high levels that the impact of policy changes on how the cost is distributed among groups in society can easily overwhelm the direct impact on total public and private spending for health care.

For Congress to succeed in its current deliberations, it needs objective, expert information on the operation of private health insurance and the impact new programs and any new regulation of private insurance may have on the behavior of individuals and employers.

Over the past two years, a major objective of the Academy's health committees has been to assist Congress in meeting its pressing need for objective information. On four separate occasions the Academy's Committee on Health has appeared before congressional committees to provide expert testimony. In addition, members of the Committee on Health have met privately with subcommittee staff and personal staff of members who are actively involved in health reform. The Academy's executive vice president also has met with members of Congress and their staffs. Finally, a number of Academy members have briefed members of Congress and congressional staff and have testified in their private capacities as health actuaries or as insurance company executives.

Among the many topics on which the Academy Committee on Health has briefed Congress are:

- the basic risks insurers face in providing group insurance, and how risks differ between small and large groups;
- the principles underlying the provision of private insurance, the importance of these principles in a competitive marketplace, and how the principles operate in practice;
- differences in underwriting practices for large and small groups, and the evolution of current underwriting practices for small groups;
- the impact of underwriting on premium costs;
- whether loss ratio requirements would force insurers to concentrate more on reducing costs and less on insuring only healthy groups; and
- the ramifications of community rating under the several definitions that are currently being given that term.

In addition, the committee has commented on specific bills at the request of their sponsors and cosponsors.

In its various public statements and private conversations, the committee had repeatedly emphasized a number of points. Among the most important of these are the following:

- The current problem is not one of access to health insurance; in fact, relatively few people are uninsurable at any time. The problem is affordability. Health insurance is expensive, because health care is expen-

sive. Creating larger pools or pooling groups with different risks cannot reduce the average cost.

❑ Within the current voluntary market, restricting underwriting practices for small groups is almost certain to have the unintended consequence of raising the average cost of insurance for small groups and reducing the number with coverage.

❑ Pure community rating means pooling all entrants of a particular class together to pay the same rate for the same level of benefits. The principle works as long as the pool has a good cross section of high and low users. However, one problem is that community rating does not reflect variation in health care costs due to factors such as age, industry, and geography. If pool membership is voluntary and rates increase, then good risks drop out, leaving behind the poorer risks for whom the community rates are a good buy. This means the rates must rise, or someone must subsidize the group.

To illustrate its points on community rating, the committee has developed and presented data on what the redistribution of premium costs would be among age groups if age rating were prohibited.

## Medicare

Medicare is one of the three major insurance vehicles that protect the aged against the risk of illness and disability. The other two are Medigap (private Medicare supplemental insurance) and Medicaid, the latter relied upon heavily for skilled nursing home care.

Medicare is designed to meet the acute care needs of the aged and disabled. Currently there are nearly 35 million beneficiaries, and the program finances about 65% the acute care costs for the aged.

The program has two components: Hospital Insurance (HI), Medicare Part A, which covers inpatient hospital care and care related to a hospitalization including short-term skilled-nursing-facility services, home health-agency visits, and hospice care. Supplementary Medical Insurance (SMI), Medicare Part B, pays for physicians' services, outpatient hospital care, laboratory and X-ray services, and medical equipment supplies.

Medicare Part A is financed through the HI payroll tax. Medicare Part B is a voluntary program in which enrolled participants pay a premium to receive benefits. Part A beneficiaries and persons over age 65 are eligible to enroll in Medicare Part B. Monthly premiums cover 25% of the program's costs, while general revenues cover the remaining 75%.

**Recent Major Reforms.** Over the past several years, congressional and regulatory activity for Medicare has focused on escalating costs and the long-term financial viability of the program. As part of the Social Security amendments of 1983, Congress enacted the prospective payment system (PPS) for hospitals under Part A of the program. The system established Diagnosis Related Groups (DRGs), and hospitals are paid a fixed fee based on the DRG of a patient at time of admission.

In 1989, Congress enacted the first major revision of the system for paying physicians in the twenty-five-year history of Medicare. The new system, called RBRVS (Resource-Based Relative Value Scale), is the result of several years of research designed to assign relative work values to the amount of a physician's time, the inherent complexity, and the risk involved to provide a given service. RBRVS also assigns values to each service for practice expenses, such as rent and office personnel, as well as for malpractice insurance premiums. The resulting scale gives relative weights to the value of different physicians' services. The weight given the service is then multiplied by a dollar value to yield the price the physician may charge for the service. Geographic adjustments are weighted to reflect differences in local practice costs.

The new RBRVS is intended to correct historical price distortions that have led to overpayments for

# Model Legislation Based on the Needs of the Uninsured

The American Legislative Exchange Council (ALEC) also looked into the uninsured problem. Before reaching a proposal, ALEC cut through all the myths and took three pertinent facts about the uninsured into consideration:

- Most small groups do not offer health insurance because they cannot afford it. Small businesses are much poorer than the large business counterparts and tend to have fewer than 25 employees, pay low wages, and have a high turnover.
- The vast majority of the uninsured are, in fact, insurable. The uninsured tend to be young, healthy, and full-time workers.
- Seventy percent of all uninsured periods last one year or less. Half end within four months, while only 15 percent last longer than twenty-four months.

Unlike the NAIC and HIAA proposals, the ALEC model does not guarantee the issue of insurance to anyone whenever they want it. Guaranteed access will encourage individuals to not buy health insurance until they become sick. ALEC believes that guaranteed access to health insurance will have virtually no impact on the problem of the uninsured, and, in fact, it will make it worse.

Most people do not need guaranteed access -- they are insurable. They need more affordable insurance. Guaranteed access will increase the floor of insurance premium. Those who cannot afford insurance now still will not be able to afford insurance. Others who can afford insurance currently might be forced out of the system because of the additional premium costs of guaranteed access.

The ALEC proposal makes affordability and rate stability top priorities, but it also encourages individuals to be insured and stay insured through its access and portability provisions. Guaranteed issue legislation encourages individuals to enter the system when they become sick because they know they will be guaranteed insurance.

# Small Group Reform Synopsis

ALEC examined four vexing issues faced by small employers today and adopted a model bill, which is currently being considered in several states. Once enacted by the states, the ALEC proposal will bring rate stability and increased health insurance access to the small group market without significantly increasing the cost of insurance. This legislation recommends reforms for the following areas of health insurance.

## Premium rating and renewal stability

By making small group insurance collectively renewable, no small group can be singled out for termination due to health, claim cost, or length of coverage (the only reasons for singular termination are for acceptable reasons, such as fraud, nonpayment of premiums, etc.). Thus, a small group knows for a fact that it will be pooled with many other small groups and that no amount of high claims cost can be used to terminate its coverage. This means that employer units can be singled out for rate increases and even nonrenewal.

By making small group insurance collectively renewable, no small group can be singled out for abusive rate increases. Again, the small business, by definition, will be pooled with many other small businesses. The most that an insurer can raise rates for *any* given group due to its own claims cost--no matter how high--is 15 percent per year.

Thus, these two concepts, used together, mean that no small group should ever need to seek replacement coverage and possibly face an access problem.

## Access

No small group can be denied coverage simply due to nature of business. This will have an immediate and significant impact on a large number of "high risk" industries, such as nursing homes, restaurants, hospitals, bars, barbers, hair dressers, off-shore drillers, miners, and long-haul truckers, to name just a few.

Furthermore, no individual who has maintained coverage continuously for a year can be denied access to a small group plan. Coverage would be guaranteed with full credit for the previous satisfaction of preexisting condition limitations. This has powerful implications for people changing jobs, young people entering the job market, self-employed people reentering the job market, and women returning to the job market, again, to name just a few.

Thus, this model act significantly improves access for both individuals and whole groups.

## Portability

This model guarantees that, once you enter the health insurance system, you can stay in. In other words, if you were to lose your employer-based coverage, you would be guaranteed the right to convert to a permanent individual health insurance plan. The benefits would be identical to those you had, and your premium would be limited to a small surcharge over the rate you would have paid had you stayed with your group plan.

Think of this as permanent COBRA that would extend down to the very smallest groups. With this, a person cannot lose coverage simply because he or she loses eligibility for coverage through the loss of employment.

Again, this has powerful implications for people leaving employment to start a new business, for the young person who ceases to be a dependent but is not joining a group which provides health insurance, for the divorce situation, or for the widow who has a small life insurance benefit to live on, no employable skills, and a chronic medical problem.

## Affordability

This model calls for the repeal of anti-managed care laws and special-interest mandated benefits.

With respect to anti-managed care laws, some states have put barriers in the way of insurers and providers that wish to form health care delivery and financing partnerships. This takes one of two forms: either the carrier cannot be selective with the providers it wishes to contract with or the carrier is limited in its ability to give strong incentives to insureds to use one provider over another. Either way, it limits a carrier's ability to forcefully affect health care costs.

With respect to mandated benefits, special-interest groups have forced carriers to build costly benefits into their plans. These take many forms and range from mandating coverage for in-vitro fertilization to substance abuse counseling. In some states, Connecticut, for example, rates are estimated to be 25 percent higher than necessary for good, quality health insurance coverage because of mandated benefits.

But these have an even more onerous implication. Large groups typically self-fund. That means they are not insured by an insurance company. The Employee Retirement Income Security Act (ERISA) allows them to be exempted from all insurance laws including mandated benefits.

Thus, the weight of anti-managed care and mandated benefits laws is carried by individuals and small businesses that have insurance plans. It is a totally inequitable and unfair situation; the big corporations can simply ignore these laws.

## Conclusion

The way to bring meaningful, effective, low cost change, and reform to the health insurance system is within our grasp. We do not need high-cost, complex solutions that will end up fixing the wrong problem.

# Proposed Model Small Employer Group Insurance Act

## This proposed act would:

(1) Make small group plans collectively renewable by state;

(2) Limit premium increases charged to individual groups with high claims;

(3) Limit rate differentials which may be charged to small groups with similar case characteristics to ratio of two to one;

(4) Limit premium charged to employers engaged in higher risk businesses;

(5) Require insurers to offer conversions identical to the group plan and limit charges for such conversions;

(6) Enable employees who have maintained prior coverage for one year to obtain small group coverage on no-loss/no-gain basis;

(7) Prevent insurers from refusing to offer group coverage to small employers based on the nature of the employer's business;

(8) Exempt small employer plans from complying with mandated benefit and anti-managed care laws.

## Provisions in this model act include:

**1. Definitions as used in this Act:**

(a) The term "insurer" means any entity which provides health insurance in this state.

(b) The terms "small employer" and "employer" mean a business which, during the most recent calendar year, employed at least [one; two; three] and not more than twenty-five employees who are eligible for coverage under a health benefit plan on at least 50 percent of that business' working days.

(c) The term "employee welfare benefit plan" has the same meaning as that term is given by the Employee Retirement Income Security Act of 1974 (29 USC Section 1001 at seq.).

(d) The terms "health benefit plan" means any employee welfare benefit plan which is insured by an insurer and which provides medical, surgical, or hospital care or benefits to employees of a small employer and their dependent. The term shall exclude any individual major medical policy which is renewable at the option of the insured except for reasons set forth in paragraphs 2(a) or 2(c) of this Act if the insurer nonrenews all policies issued on the same policy form in this state. These terms also exclude any policy of group insurance which is not designed, administered, or marketed as a health benefit plan to be provided by an employer for its employees.

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(e) The term "similar plans" means plans which do not materially differ from one another in any of the following respects:

(1) The set of services covered;
(2) Utilization management provisions;
(3) Managed care network provisions;
(4) The criteria used by the insurer in underwriting coverage under a plan where variations in such criteria may reasonably be expected to produce substantial variation in the claims costs incurred under the plan.

(f) The term "case characteristics" means demographic and other relevant characteristics as determined by the insurer that are considered by the insurer in the determination of premium rates for a small employer but excluding:

(1) Claims experience;
(2) Health Status; and
(3) Duration of coverage since date of issue.

**2. Nonrenewal.**

(a) No insurer providing coverage under a small employer health benefit plan shall nonrenew such plan except for any of the following reasons:

(1) Nonpayment of required premium;
(2) Fraud or misrepresentation on the part of the employer;
(3) Non-compliance with provisions of the plan including provisions regarding minimum numbers of or percentages of insured employees;
(4) Nonrenewal upon ninety (90) days written notice with respect to all small employers in this state.

(b) An insurer that exercises its right of non-renewal as provided in paragraph 2(a) (4) may not accept any new small employer business for a period of five (5) years after it provides notice of such non-renewal;

(c) Nothing herein shall be deemed to prevent any insurer from rescinding or non-renewing the coverage of any individual employee or dependent of such employee for fraud or material misrepresentation to the extent allowed by the law of this state.

**3. Experience Rating.**

(a) The premium rate charged in connection with a small employer health benefit plan shall be the same for all small employers with similar case characteristics covered under similar plans. Notwithstanding the foregoing, an insurer may adjust the premium charged to an employer in connection with the plan based upon that employer's claims experience, the health of persons covered under the plan, and the duration of coverage since the date of issue, provided that the total premium shall not exceed two times the lowest premium charged to an employer with similar case characteristics. For purposes of this paragraph, the term "average premium" means the arithmetic average of the lowest and highest premium rates charged to employers with similar case characteristics.

(b) Subject to the limitations set forth in paragraph 3(a), the percentage increase in the premium rate charged to a small employer may not exceed the sum of:

(1) The percentage change in the new business premium rate for employers with similar case characteristics as measured between the first day of the calendar year in which the new rates take effect and the first day of the prior calendar year; plus
(2) An adjustment not to exceed 15 percent annually based on claims experience, health status, or duration or coverage; plus
(3) Any adjustment due to changes in the coverage provided or changes in the case characteristics of the employer.

**4. No Excluded Occupations.**
No insurer may refuse to offer coverage under a health benefit plan to employees of a small employer based solely on the nature of the employer's business. An insurer may charge additional premium based on the nature of the employer's business, but the total premium may not exceed 150 percent of the premium which would be charged to that employer under paragraph 3 of this Act without regard for the nature of the employer's business.

**5. No Mandated Benefits.**
No statute or regulation of this state which mandates the provision of specified health insurance benefits or which prohibits or limits the use of managed care shall be construed to apply to any small employer health benefit plan or any conversion policy provided in accordance with paragraph 6 of this Act.

**6. Conversion Privilege.**

(a) Any person who has been continuously covered for at least 90 days under a small employer health benefit plan and who thereafter loses such coverage by reason of:

(1) Termination of employment;
(2) Reduction of hours;
(3) Divorce;
(4) Attainment of any age specified in the plan;
(5) Expiration of any continuation of coverage available as required by state or federal law;
(6) Cancellation of the plan by the employer or nonrenewal thereof due to benefit plan which provides medical, surgical, or hospital care or benefits; employer provides coverage to any employee under any employee welfare (b)Nonrenewal of the plan as set forth in paragraph 2(a)(4) of this Act; shall,

upon written request to the insurer, be entitled to receive an individual conversion policy. Such request shall be made within 31 days of loss of coverage. The premium for any given period shall not exceed 135 percent of the rate that would have been charged with respect to that person had the person been covered as an employee under the plan during the same period. When the plan under which such person was covered has been canceled or nonrenewed, the rates shall be based on the rate which would have been charged to such person had the plan continued in force as determined by the insurer in accordance with standard actuarial principles.

(c) Benefits provided under such conversion policy shall not be less than the benefits provided under the plan. The insurer may apply any benefits paid under the plan against the benefit limits of the conversion policy provided that if it dies so, it shall also credit the insured with any waiting period, deductible and coinsurance to the extent credited under the plan.

7. **New Employees Who Were Previously Insured.**
This provision applies only to persons who first become employees of an employer following the date an insurer first insures any employee of such employer under a given plan. No insurer of a small employer health benefit plan shall refuse to accept for coverage, under the plan, any person, who on the date of application for such coverage would be eligible therefore, except for underwriting considerations relating to such person's health status, provided such person has, as of that date, been continuously covered under an employee welfare benefit plan or other health insurance policy (other than any policy issued by or in connection with any state high risk insurance pool) for a period of one year. Nothing herein shall require such insurer to provide benefits greater than those provided to a person insured as a standard risk under the small employer health benefit plan or greater than those that would have been provided under such prior coverage had it remained in force. For purposes of this paragraph, a person shall be deemed to be continuously covered for a period of one year if such person is insured at the beginning and end of such period and has not had any breaks in coverage during such period totaling more than thirty-one (31) days.

**This legislation should be accompanied by the Discontinuance and Replacement Model Act.**

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STATEMENT OF THE HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

Good morning Mr. Chairman and members of the Committee. I am Alan Magazine, President of the Health Industry Manufacturers Association ). HIMA is a national trade Association representing nearly 300 companies that manufacture medical devices, diagnostic products, ad health care information systems. HIMA companies' sales represent more than 90 percent of the domestic market. I appreciate the opportunity to appear before you to discuss HIM's perspective on S. 1872, the Better Access to Affordable Health Care Act.

HIMA supports a market-based approach to health reform that will expand access to care, reduce costs, and maintain the high quality of health care Americans have come to expect. We believe that the American health care delivery system is the best in the world. Any reforms should build on this existing solid foundation, and individual choice should be the principal mechanism for determining medical expenditures, utilization of health services, ad resource allocation.

Mr. Chairman, the Better Access to Affordable Care Act that you have introduced with 24 of your colleagues is a market-based approach that is consistent with the principles that HIMA companies endorse.

You have addressed the problem of "job lock" that makes workers fearful of changing jobs. Today there is nothing to prevent a new carrier from excluding employees or their dependents from coverage because of pre-existing conditions. S. 1872 would limit the extent to which workers could have their coverage restricted.

S. 1872 uses minimum Federal standards for the availability of affordable health insurance to attack the problem of "cherry picking" that some insurers use to exclude high-risk employees. HIMA is especially interested in the Health Care Cost Commission that this bill authorizes. This Commission would advise Congress and the President on methods to reduce health care costs.

In addition your bill would increase the tax deduction for the self-employed, permit flexible benefit packages, ad expand Medicare screening ad preventive care services.

This is a thoughtful, balanced bill that offers realistic solutions to many of the most serious problems in our health care system. Mr. Chairman, HIMA would like to commend you and your colleagues for developing S. 1872 and bringing it before this Committee for consideration.

HIMA has not proposed or endorsed any global health care reform plan. We claim no special expertise in many of the insurance and tax laws that are involved in formulating a comprehensive plan. HIMA is using the principles I mentioned earlier to evaluate all of these proposals, and we will continue to monitor them closely.

However, HIMA companies do have extensive expertise in the development and use of medical technology. We are committed to using this expertise to fashion strategies that we believe will reduce costs without compromising quality of care. We will tailor these ideas to fit within the framework of any major health reform plan considered by Congress.

HIMA companies would like to suggest an amendment to S. 1872 that we believe would best utilize our expertise and would contribute to you? objective of controlling health care costs. This amendment would add representation from the medical technology industry to the Health Care Cost Commission.

Section 401 of S. 1872 would establish a Health Care Cost Commission (Commission). The Commission would be composed of individuals with national expertise in health insurance, health economics, health care provider reimbursement, and related fields.

An analysis of the Commission's duties in section 401(c) shows that medical technology manufacturers have expertise in these areas. For example, in its annual report to Congress and the President the Commission must include information on the sources of health care costs.

An analysis of the cost of medical technology and its impact on the total cost of health care should be included in this annual Commission report. There is no question that there are dollar costs associated with the development and use of technology, and there is no sector of the health care community that knows more about the cost of developing and using medical technology than this industry.

HIMA companies spend considerable time and resources generating clinical data about their products. They invested an average of 6.3 percent of sales in research and development D), which amounted to more than $2 billion in 1991. A good deal of this investment, which is double the national average for U.S. companies, results in clinical data that can be of great value in analyzing health costs. We believe this is the most compelling reason for putting industry representatives on the Commission.

Another good reason for including representation from this industry on the Commission is that one of its directives is to study the impact of administrative costs on national health spending. A whole subset of HIMA's membership develops and manufactures health care information systems.

These manufacturers are developing and producing state-of-the-art hardware and software for bedside patient terminals and medical billing systems. This group would be an invaluable resource in the effort to reduce administrative costs.

Thank you, Mr. Chairman, for the opportunity to present HIMA's views on the Better Access to Affordable Health Care Act. We respectfully request that you seriously consider adding an amendment to the bill that will include on the Health Care Cost Commission representation from our industry. These companies are the undisputed experts on the development of medical technology, and we believe they would make a significant contribution to the Commission's work.

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## Statement of the Interreligious Health Care Access Campaign

Mr. Chairman and members of the Committee, this testimony is presented in the name of the Interreligious Health Care Access Campaign on behalf of the undersigned religious organizations. We are working together to advocate for legislation which will provide access to comprehensive health care for everyone living in the United States. To accomplish this, we believe that systemic reform of the current health care system is required to insure that our Nation does not continue to waste our resources, provide inequitable care and leave most of us without real health security.

The religious community represented by this testimony applauds the members of the Senate Finance Committee for providing the opportunity to the public to give input into the debate on health care. The religious communities represented in this testimony are made up of consumers, providers, insurers and employers. We are concerned about and have examined the technical aspects of the health care delivery system. Our driving concern, however, stems from our religious commitment which holds that everyone living in the United States of America today has a right to health care.

Our religious entities have a long history of commitment to provide health care. We are providers of health care services through the hospitals we operate, nursing homes, community health centers and congregations. We are also institutional and congregational employers who strive to provide benefits for our employees. However, we too are challenged by the continued escalation of the costs to provide health care coverage and the diminishing value of the health care dollar spent.

Our testimony is the result of listening to many sectors and voices throughout the country: headquarters personnel, religious-based health providers, communities of need (such as people with disabilities), national and State public policy offices, women's organizations, racial and ethnic groups, hospital chaplains and more. We are responding to S. 1872 based on a consensus document entitled "Working Principles for Assessing National Health Care Legislation," which guides the work of the Interreligious Health Care Access Campaign.

STATEMENT OF CONCERN

From the viewpoint of the religious community, the expressions of concern from all sectors of our country, along with the tremendous amount of legislative activity in Congress and the State legislatures, demonstrate the need for comprehensive reform of the health care delivery system and the methods of financing it. The cost of health care has become a burden on individuals, families and the Nation. It is clear that some remedy is needed; however, we believe that the nature of the delivery system demands wholistic reform. Therefore, we approach the analysis of S. 1872 as legislation which may indeed impede progress in enacting systemic reform. This country has some of the best health care that money can buy, yet it is unavailable to too many who cannot afford it.

The February 1991 General Accounting Office report on HEALTH INSURANCE COVERAGE which was prepared for Senator Riegle stated that in 1988, about 32 million Americans (under age 65) did not have some form of health insurance coverage. Those 65 and older did not seem to be as adversely affected as others by lack of coverage because about 99 percent had Medicare or private insurance. The GAO report revealed the uninsured tend to be concentrated among the lower income, people of color, youth, unmarried and less educated segments of the population. It was particularly significant that a large majority of the uninsured were employed. Part-time/part-year workers represented the highest percentage of uninsured workers in the States examined. However, full-time workers make up a substantial share of the uninsured population in many States.

Many people who have some form of health insurance or other health coverage are finding they are not secure. Religious institutions, like other employers, are struggling to pay for health insurance benefits. Too many of our workers, with the coverage we strain to provide, end up with out-of-pocket costs that their salaries are not high enough to absorb.

The United States is rationing health care. People who can afford to pay or who have health insurance receive health care while low income people receive minimal care or have to go without attention to their health needs. We are denying care and delaying care while we have a surplus of hospital beds, medical personnel and medical technology. This country is paying enough to deliver high quality medical care to everyone within its boundaries.

The religious community represented by this testimony believes NOW is the time to develop and deliver a fully comprehensive and accessible health care system. We must stop the piecemeal approach to reform and the incrementalism in solving special problems that have brought us to this current state of affairs. The religious community believes that health care is a basic right which flows from the inherent dignity of each person. Extended and continuing conversations within the religious community have helped us to see clearly that an adequate solution must (1) serve those who do not have access to health care, and (2) serve those who are in danger of being pushed out of the system because of rising costs.

To provide the services needed requires that our health care system must also work for those who are the providers. This will not happen unless we can significantly restrain rising costs and distribute costs on a more equitable basis. Moreover, targeting only one sector of the health delivery system for reform will not correct a system gone awry.

Our share of the gross national product spent on health care is the highest in the world and rising at about half a percent per year. We believe that systemic reform can be accomplished without a significant increase in the costs of health to the society. We have a substantial supply of health care capital already in place. Indeed, we have an expensive oversupply of hospital rooms and high technology in some places. Systemic health care reform would distribute health care capital more equitably across the United States.

The religious community, like the general public, is deeply concerned about the impact of being uninsured or underinsured. The attempt to contain cost as proposed in S. 1872 may lead to limiting access to health care even more. We believe the way insurance plans are structured contribute to the problems of cost and access.

LEGISLATIVE ANALYSIS

**Principle: We seek a national health care system with financial support drawn from the broadest possible resource base. Financial support realized from individuals (and corporations) should be progressive, based on the ability to pay. Funding should be generated in an efficient and least costly manner.**

S. 1872 is essentially an insurance reform proposal. The National Association of Insurance Commissioners (NAIC) has the role of establishing standards for small employer health insurance. This seems to assume that reshaping services offered through the insurance industry will address the problems of our health care system. It focuses attention on the small group market, so the problems of individuals seeking insurance, people in larger groups and employers who self-insure remain unaddressed. Repair of the system in the manner proposed is carried on the backs of the consumers who would have less coverage and more out-of-pocket expenses; therefore, some people would pay more money for even less services. Insurance reform does not get to the underlying problems of rising health care costs and declining access. It provides no guarantee that health care coverage will be affordable.

We believe use of the private insurance model to expand access is too costly. Under this proposal, it is possible to use grant funds for administrative costs including marketing and outreach efforts, negotiations with insurers, and performance of administrative functions such as eligibility screening, claims administration and customer services. The $10 billion costs spread over five years will not guarantee universal access; people will still fall through the safety net.

Commercial insurers cannot provide the highest cost efficiency and still offer accessibility to all. Private insurers, who spend 33.5 cents to provide a dollar's worth of health service, cannot compete with a government run insurance system such as Medicare, which spends only 2.5 cents per health care dollar for administration. A universal access system administered by a nonprofit agency would reduce costs by eliminating the need to determine coverage, eligibility, risk status and by eliminating marketing costs.(June 1991 GAO report on Canadian Health Insurance)

**Principle: We seek a universal access national health plan which would provide services based on principles of equity, efficiency, and quality of output. The process of paying for health services should be equitable, cost effective and easy to administer and understand.**

**Principle: We seek a national health care plan which provides the following benefits for the whole population of the Nation: programs of health promotion and risk reduction, including prevention of illness and disability through pre- and post-natal care, immunizations and epidemiologic services; provision of early screening, diagnosis and treatment through physical examinations (inclusive of dental, eye and hearing care); programs of mental health which provide services to enhance the capacity of individuals to function in society to diminish emotional and cognitive distress and to treat neurological disorders/mental illness.**

We have serious concerns that our comprehensive goals regarding availability are not presented in this bill. In our opinion, the provisions in S. 1872 which guarantee availability of insurance to all employers in a State does not provide accessibility to all employees of small businesses. The guarantee is for the availability of a health insurance plan to all small employers in a State but employers have options about participating. Insurance may be available to all employers, yet coverage may still be unaccessible for employees and their families. In a 1987 survey of small employers, fewer than 20 percent cited unavailability as the reason they did not provide health insurance (CBO report, April 1991). Guaranteed availability does not eliminate the potential for medical underwriting which is common for groups of under 15 persons, and is increasingly including groups with as many as 99. Even in assigning high-risk groups among all insurers, the costs for similar insurance would still be higher for small employers than for larger ones. The unequal burden between large and small employers will remain rather than spreading risks throughout the entire population on the basis of ability to pay.

We find the benefits package to be inadequate. The basic package does not include mental health services. There are no prescribed limits on cost sharing although it does allow for an unspecified out-of-pocket limit. Since this bill would allow States to go to minimum benefits, some employees may lose benefits that are currently mandated by some States (e.g. mental health and OB/GYN benefits). This provides the potential for small group insurers to discriminate against segments of the population with special needs or chronic health conditions.

We commend the bill for addressing the concerns about preexisting conditions and portability. The bill limits preexisting condition waiting periods to six months for conditions that are diagnosed or treated in the three months prior to coverage. However, some people will remain at risk of not getting care or will have to bear exorbitant expenses until time-eligibility is met. Many employees of small employers are engaged in a relatively low wage job. If this is combined with wide variations in rating practices (20 percent variation), this could lead to discrimination in hiring of women, older people and people with disabilities. This exacerbates the needs of individuals or families.

We understand that the introduction of a small employer insurance proposal is not presented as a comprehensive solution to the health care crisis. *However, we repeat we believe that premature consideration of legislation will actually impede progress in enacting the systemic reform that is needed.* The timetables for studies and reports contained in the bill suggest a holding pattern through 1995. In the meantime, State laws that offer consumers protection in the form of mandated benefits, requirements for the managed care industry, and regulation of utilization review are eliminated; thus exposing consumers to greater erosion of health care security in the interim.

We are enclosing a copy of the Interreligious Health Care Access Campaign Working Principles for Assessing National Health Care Legislation. We shall continue to use these principles in assessing legislation.

Attachments.

# Interreligious Health Care Access Campaign

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March 4, 1992
Testimony regarding S.1872

The following religious organizations, which are members of the Interreligious Health Care Access Campaign, have endorsed this testimony:

Church of the Brethren Washington Office
Church Women United
Commission on Religion in Appalachia
Evangelical Lutheran Church in America
General Board of Church and Society, The United Methodist Church
INTERFAITH IMPACT for Justice and Peace
National Council of the Churches of Christ in the U.S.A.
Presbyterian Church (U.S.A.), Social Justice and Peacemaking Unit
United Church of Christ, Office for Church in Society

The following religious organizations, which are not members of the Interreligious Health Care Access Campaign, have also endorsed this testimony:

AIDS National Interfaith Network
Jesuit Social Ministries, National Office
NETWORK: National Catholic Social Justice Lobby

# Interreligious Health Care Access Campaign*

## Working Principles for Assessing National Health Care Legislation

SUMMARY: We seek a national health care plan which grants universal access to health care benefits, including access to primary and acute health care, immunization services, early diagnostic and treatment programs, provider and consumer education, programs of extended care and rehabilitation, mental health and health and wellness promotion. Such a program should provide for education, training and re-training of health care workers as well as just compensation and affirmative action in hiring. An effective plan will provide for cost containment, equitable financing and assure quality of services.

OUR FIRST PRIORITY IS ACCESS TO PRIMARY AND ACUTE HEALTH CARE PLUS IMMUNIZATION SERVICES, EARLY DIAGNOSTIC AND TREATMENT PROGRAMS, AND PROVIDER AND CONSUMER EDUCATION. PROGRAMS OF EXTENDED CARE AND REHABILITATION AND PROGRAMS OF MENTAL HEALTH ARE VERY IMPORTANT ADDITIONS.

Principles: The following principles guide our assessment of national health care legislation. The unifying concern is a commitment to work to enact legislation that provides universal access to health care benefits and systemic reform of health services through a national health care plan.

1. We seek a national health care plan which serves everyone living in the United States. Participation must not be limited due to discrimination on the bases of race, income, gender, geography (urban or rural), age, disability, health status, sexual orientation, religion, country of origin, or legal status.

2. We seek a national health care plan which provides the following benefits for the whole population of the nation:

   a. Programs of health promotion and risk reduction, including:
      (1) Prevention of illness and disability through pre- and post-natal care, immunizations, and epidemiologic services.
      (2) Education of providers and individuals about early symptom identification, appropriate use of health care services through risk assessment, public health materials, and educational events.
      (3) Provision of early screening, diagnosis and treatment through physical examinations (inclusive of dental, eye, and hearing care.)

   b. Programs of primary and acute care which would treat health problems by medical and para medical professionals in hospitals, health clinics, and through outpatient services.

   c. Programs of extended care and rehabilitation which treat health problems through services offered by health care providers in home settings, hospitals, clinics, extended care facilities, specialized nursing facilities congregational settings and hospice care.

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** These Working Principles are a consensus document created by religious leaders through five National Consultations over a period of two years. They are the basis for the Interreligious Health Care Access Campaign, formalized today, January 7, 1992.*

d. Programs of mental health which provide services to enhance the capacity of individuals to function in society to diminish emotional and cognitive distress and to treat neurological disorders/mental illness.

The more benefits included in any single piece of legislation, the more positively we will regard that bill.

3. We seek a national health care system with financial support drawn from the broadest possible resources base.

a. Financial support realized from individuals (and corporations) should be progressive, based on the ability to pay.

b. Funding should be generated in an efficient and least costly manner.

c. Consideration should be given to taxes on products and manufacturing methods that damage health to help fund the health care program.

4. We seek a national health plan which guarantees access to care everywhere in the nation.

a. Legislation should provide for integrated planning, coordination and communication between all organizations affected by this plan.

b. To assure such access, we seek a plan in which benefits are defined and standards of evaluation established at the national level. This suggestion is compatible with state administration of national standards.

c. The agencies or commissions, which establish benefits, standards of evaluation for the quality of health services, guidelines for medical practice and the authorization and geographic location of appropriate service providers, must include participation by citizens, health professionals, and governments.

d. Delivery of health services should not be denied on the basis of behavioral patterns, illness diagnosis, treatment plan or facilities utilized.

5. We seek a national health plan which sets prospective budgets for payments to health care institutions from federal funds in a way that assures services for all parts of a region.

a. The needs of underserved rural and urban areas must be met.

b. Unnecessary duplication of services should be eliminated.

c. This principle does NOT mean that we favor "nationalized" medical services or the ending of administrative control by independent health care providers.

d. The establishment of prospective budgets should include health care provider participation, and should be based on realistic and adequate reimbursement levels.

6. We seek a national health care plan that is sensitive to the needs of persons working in the various components of the health care system.

a. The plan must provide for the education and training of health care workers and for affirmative action programs in the recruitment, training and employment of these workers.

b. The plan must provide for just compensation for all workers at all levels of the health care system.

c. The plan must provide for retraining and placement of workers displaced by changes in the health care system.

7. We seek a universal access national health plan which would provide services based on principles of equity, efficiency and quality of output. The process of paying for health services should be equitable, cost effective, and easy to administer and understand. The administration of claim reimbursement should be operated on a regional or state basis.

8. We seek a national health plan which sets a national budget for health education and wellness promotion.

9. We seek a national health care plan which promotes effective and safe innovation and research in medical techniques, research on the delivery of health services, and research on health practices of individuals and families. Priority in health research should be given to issues that benefit large sectors of the population and to those which address the concerns of women and people of color.

10. We seek a national health care plan which reduces the burden of malpractice litigation. Such a reduction should be consistent with appropriate discipline for unprofessional acts by medical providers and should provide appropriate recompense for injured patients.

11. We seek a national health care plan which significantly reduces the current rapid inflation in the costs of providing medical services. Several of the above principles address this concern, including: the setting of standards for the quality of medical care and guidelines for the appropriateness of medical services, regional planning and prospective budgeting for health institutions, limiting the effects of malpractice litigation, inclusion of citizens and governments on key regulatory boards, and in other ways. However, the pursuit of cost containment should not place undue burdens on medical providers or upon those who receive services. Where possible, individuals should have a choice of medical providers.

12. We recognize that universal access to health care services and the systemic reform of the delivery of health services is only one aspect of improving the health of the population. The national health plan should also provide the federal health leadership in preventive health care that can address the need to improve the health of the population by assessing the health impacts of standard of living issues, housing, nutrition, physical fitness, environmental safety, and sanitation.

## Statement of Magic Carpet Travel Agency, Inc.

My name is John J. B. Miller. I am Managing Director and principal owner of Magic Carpet Travel Agency, Inc., located at 1136 Junction Highway, Kerrville, Texas 78028. There are only 3 of us in the office, myself and 2 employees, one of whom is also a part-owner. The company pays half of her health insurance. The other one does not want it, because she has coverage under her husband's policy. I no longer have health insurance, the reasons for which I will explain later.

While I support the aims of S. 1872, I fear that if it is enacted, the result will be the massive exodus of insurance firms from the health insurance business. Many insurance firms have left it already, because, even if profitable, it gives them too much grief. Insurance companies do not like to be told whom they have to cover, and I believe that if this bill is enacted, they will flee, and you will be left with one insurer, like the Canadian system, which is what I am advocating anyway.

In my own case, I formerly had health insurance with a company called Commercial Life, which was a subsidiary of Dun & Bradstreet and very reputable. In 1984 my left kidney was removed with a malignant tumor. They paid a substantial claim. A year later, Commercial Life decided to stop offering health insurance, and I was left to find another insurer. I should have sued them had I known how difficult this would be. Even though there has been no reoccurrence of the cancer, I have been refused coverage by one company after another. Finally I found a small company in Fort Worth, Texas that would issue me a policy, but it contained an exclusionary rider for anything to do with cancer, or with the urinary tract. In other words, a doughnut with a big hole. It had a deductible of $2,000, but I did not mind that, because I am in comfortable circumstances; still a major illness conceivably could wipe me out. However, when they raised their premium nearly 50% a year later, I decided that I was paying too much for too little, and dropped the policy.

If S. 1872 passes, what happened to me will happen to many people. I would like to have catastrophic health insurance, but I know that private insurers don't want to offer it to me. If they are forced to, they will simply give up health insurance. What is needed is a single insurer; a quasi-government agency on a national level.

Thank you for giving me the opportunity to express these views.

NATIONAL ASSOCIATION OF REHABILITATION FACILITIES,
*Washington, DC, March 4, 1992.*

Hon. LLOYD BENTSEN, *Chairman,*
*Senate Finance Committee,*
*205–SD,*
*Washington, DC.*

Re: S. 1872, Better Access to Affordable Health Care Act of 1991

Dear Mr. Chairman: This statement is submitted on behalf of the National Association of Rehabilitation Facilities (NARF). NARF is the national voluntary association of community based facilities. Our membership includes over 800 medical, vocational, and residential facilities. Our medical membership includes freestanding rehabilitation hospitals, rehabilitation units in general hospitals, and comprehensive outpatient rehabilitation facilities. Almost all of them are Medicare providers. The hospitals and units are exempt from the Medicare prospective payment system (PPS).

NARF is interested in and concerned about the current health care reform debate. Recently our Board of Directors approved the Statement of Principles against which to Measure Health Care Reform and Characteristics of a Reformed Payment System as they relate to rehabilitation. Additionally, NARF supports the National Rehabilitation Caucus' statement on health care reform, also attached.

## I. BACKGROUND

Rehabilitation is an integral—not peripheral—part of the current health care delivery system. It prevents numerous complications as well as preventing reinstitutionalization and extended institutionalization. Over 80 percent of people receiving rehabilitation services return to their homes, work, schools, or an active retirement.

Rehabilitation services are individualized, goal-oriented medical services designed to maximize functional ability and promote quality of life and independence for people, who through accident or illness, have acquired a temporary or permanent disability. These services are provided by qualified health care professionals including physiatrists, occupational therapists, physical therapists, speech-language pathologists, audiologists, rehabilitation nurses, respiratory therapists, and others. Rehabilitation services are delivered in a variety of settings, depending on diagnostic and therapeutic requirements, including hospitals, nursing facilities, comprehensive outpatient rehabilitation facilities, rehabilitation agencies, and clinics.

Millions of people receive rehabilitation services annually—people who have had a heart attack or stroke, have arthritis, cancer or a neurological disorder, have had joint replacements or have experienced a traumatic accident or debilitating illness, as well as children with congenital or acquired physical impairments.

Peter Drucker, a well known management consultant, has said, "The health area in which we have made the greatest progress in recent decades has been rehabilitation; to restore badly injured people to functioning. Of all health care dollars, they are the best spent."

Rehabilitation is a cost effective alternative to extended acute care. A survey conducted by the Health Insurance Association of America found a savings of $11 for every $1 invested in rehabilitation services and a savings per claimant of between $1,500 and $250,000. Similar results have been shown in studies conducted by several insurance and case management companies. Northwestern National Life Insurance Company finds that rehabilitating workers can save companies $30 for every $1 spent. We believe premium costs, if any, associated with coverage of medical rehabilitation services are modest when contrasted with potential savings due to prevention of complications, institutionalization and extended institutionalization. For example, according to 1990 figures from Blue Cross/Blue Shield of Massachusetts, the cost of full coverage in inpatient and outpatient settings of occupational, physical, and speech language pathology therapies and services amount to 1.5 percent of the average individual monthly insurance premium or $3.70.

## II. COMMENTS

In light of the above, we have reviewed S. 1872 and wish to offer specific comments. We commend you for introducing this measure to tackle one aspect of the health care dilemma and for being one of the leaders in the health care reform debate. Our comments follow.

*A. Coverage*

Our primary concern is the approach taken in the standard benefits package and the basic benefits package as defined in Section 2113 (b) and (c). We acknowledge that the approach is to allow the National Association of Insurance Commissioners to draft a model act and regulations and to allow the States to enact their own definitions. However, our first recommendation is that the definition of inpatient and outpatient hospital care be clarified to include inpatient and outpatient rehabilitation care. Second, we recommend that community based medical rehabilitation services based outside the hospital also be included in the benefits package. To do so would parallel current practice in covering these services. The Medicare definition of hospital specifically references rehabilitation hospitals and the therapeutic services they provide. Medicare has traditionally covered inpatient and outpatient rehabilitation hospital services since 1965. See Sections 1861(b), definition of inpatient hospital services, and (e) definition of hospital, (s) definition of medical and other health services, (p) outpatient physical therapy services, (g) outpatient occupational therapy services, and (cc) definition of a comprehensive outpatient rehabilitation facility.

Many Medicaid programs also cover inpatient and outpatient rehabilitation hospitals services. At least 75 percent of the States cover outpatient physical therapy and each State offers at least one outpatient rehabilitation service. See Sections 1902(a)(10) and 1905(a)(13).

Also commercial insurers recognize these services. The Health Insurance Association of America has issued two bulletins regarding the coverage of inpatient hospital services by insurance carriers.

Finally, many Blue Cross and Blue Shield plans cover at least inpatient rehabilitation hospitals and units and the services they provide.

*B. Payment/Financing, Section 1103 Study of the use of Medicare Rates*

Currently most rehabilitation hospitals and units are exempt from the Medicare diagnosis related group (DRG) based prospective payment system (PPS) under which most acute care hospitals are paid. They were excluded because the DRGs did not include data from rehabilitation hospitals and units and do not recognize diagnoses with long lengths of stay.

We have two concerns with the use of the current Medicare payment methodology for private plans. First, the current system, known as TEFRA, pays excluded facilities on the basis of cost subject to a ceiling limitation. Hospitals are designated a base year based on the date of exclusion from the PPS. At the end of the base year the Medicare costs are divided by the number of Medicare discharges to create a cost per discharge. This amount is updated annually, theoretically to recognize the cost of inflation. The maximum amount a hospital receives in subsequent years is the number of discharges times the cost per discharge. If the hospital's costs exceed this cost per discharge it loses money. If its Medicare costs are less it receives a small incentive payment. TEFRA is based on the presumption that all operations remain stable. It presumes that case mix, severity, utilization, and patient acuity remain stable; that the updates will be adequate to account for inflation and any changes; and that management can keep costs within the targets if there is any change. However, in reality, this is not true. The same assumptions on which TEFRA was based are now proving to be its weaknesses. Case mix, severity, utilization, and acuity do change and cause facilities' costs to increase. The net result is that for a facility to stay below the limits it must cut length of stay. One way to achieve this is to take less complicated cases. Hence, there is an inherent bias against admitting more complicated cases that could benefit from rehabilitation.

Therefore, we recommend that TEFRA be changed to address the defects in the system for payment beyond Medicare at this time. Any such change must also recognize all the real costs of delivering health care that Medicare and the TEFRA system do not do. NARF is investigating possible patient classification systems that may lead to a way to estimate resource utilization and recognition of the full costs of treatment of Medicare patients.

Second, Medicare currently covers the elderly and disabled. If expanded to all populations, any payment methodology would have to be amended considerably to recognize the medical needs and therefore costs of these new populations. These include pediatric cases, those who serve spinal cord and traumatic brain injury, and numerous rehabilitation cases in the younger age groups.

*C. Definition of Small Employer*

Section 2103(c) defines small employer as one with 1-51 employees. We recommend that this number not be increased, and would prefer that it be decreased to 25 employees.

*D. General Requirements*

Section 2111(c)(2)(B) outlines the alternative mechanisms that are to be available within a State to assure insurance availability to the defined small employers. This mechanism includes a program for assigning high risk groups among all insurers. We support the need to address and assure access for high risk groups. NARF has heard too frequently of occupations that have lost insurance or cannot afford it. Many times we find that the patients our facilities serve are in these occupations.

*E. Community Rating*

Section 2112(c) allows insurers to make certain adjustments for premiums across small employers and requires a form of community rating based on an area no smaller than a county or an area that includes all areas in which the first three zip code numbers are the same. We support community rating over group rating to lower premium costs by spreading the risk.

*F. Copayments and Deductibles*

Sections 2113 (b)(5) and (6) outline the allowable deductible and copayments. We simply caution that the 20 percent amount may prove too high for some persons with disabilities. The same may be true of the deductible levels, but we commend you for putting a cap on the amount by percent. We make the same observation with respect to (7), limit on out-of-pocket expenses.

*G. Preexisting Conditions*

In Section 2111(e)(1) we support the provision on non-discrimination based on health status. In (e)(2) we support the intent to limit exclusions for preexisting conditions to 6 months. We would recommend that all preexisting conditions clauses be deleted to eliminate the possibility of lack of receipt of health care for persons with disabilities and therefore the almost total bar to coverage that these provisions create.

*H. Portability*

Title III seeks to assure the portability of insurance so that employees are not faced with staying in jobs that are unsatisfactory or losing health insurance if they leave. This is the fabled "job lock." We support the nondiscrimination provisions in (e) (1) and have the same comments on preexisting conditions mentioned above which is in (e) (2).

*I. Managed Care, Health Care Cost Containment Title IV Section 401(c)(3)*

This section requires the Commission to make recommendations to the Secretary for standards for managed care plans. Section 402, creating section 2114 of Title XXI, sets forth a voluntary certification program for managed care plans and utilization review programs.

NARF has several concerns with these types of programs based on the current experience of our members. First, with respect to any type of utilization review program, we recommend that reviewers have experience and training for the area they are reviewing. This means that physical therapists must review the work of other physical therapists and physiatrists or other physicians with training and experience in rehabilitation must review the work of similarly qualified physicians. All too frequently this is not the case with disastrous results. Secondly, under Section 2114 (b), Requirements for Certification, we recommend that (D) be emphasized. Under current managed care plans for the non-elderly, our members find that many HMOs are not providing full and adequate coverage for inpatient and outpatient rehabilitation hospital and other outpatient rehabilitation services. In some quarters this is due to a fear of additional costs. Even the federally qualified HMOs that by Federal regulation are to deliver 60 days of rehabilitation services often do not. The result is that the patient is not restored to an independent life when this may be possible. For many patients, this means transferring to Medicaid and then finding themselves dependent on services based on the lottery of which State they live in. Also, we have heard from our members in over 9 States that Medicare risk contracting HMOs will not inform enrollees about their rehabilitation benefits and send them to a less appropriate level of care, denying them a needed benefit that in many cases, as with the younger age groups, is medically necessary and required because of illness, injury, or their condition.

We recommend that these requirements for certification be examined more closely given the comments above and we also recommend that (D) be amended by removing the terms "immediately" and "unforeseen." The burden of showing the need for the services and the impact of what happens if care is not provided not be put on the enrollee or his or her family. Illness and injury and their results and complications do not go on hold while an administrative hearing is held.

Finally, we do not agree with Section 2114(c) and the provision that would allow States to waive these programs, even given the exceptions in (c)(2).

*J. Other*

*1. Outcomes Research*

We support continued outcomes research in Section 403. With respect to rehabilitation, we firmly believe that it will be shown to be cost effective and efficient.

*2. Medicare Prevention Benefits, Title V. and Prevention*

We commend your inclusion in the benefits package discussed above of several recognized screens and procedures which when utilized help detect disease early and thereby prevent death and serious illness. Rehabilitation plays a major role in prevention of certain complications such as bed sores and deep vein thrombosis, for example.

We also support coverage for these procedures and services under Medicare.

We would be pleased to discuss any of these concerns and recommendations with you or your staff as an association of providers, the Nation, and the Congress face these major health care issues.

Sincerely,

CAROLYN C. ZOLLAR, *General Counsel, Director of Government Relations/ Medical*

Enclosures.

NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

James S. Liljestrand, M.D.
*President*

Robert E. Brabham, Ph.D.
*Executive Director*

**ACCESS REHABILITATION: A FOCUS FOR THE HEALTH CARE DEBATE**

The following are several principles for a reformed health care system as reviewed by the NARF Board of Directors. They are excerpted from an upcoming publication "Access Rehabilitation: A Focus for the Health Care Debate."

**I. GENERAL PRINCIPLES AGAINST WHICH TO MEASURE HEALTH CARE REFORM**

No existing payment mechanisms meet rehabilitation's needs exactly. There are a number of principles against which to evaluate health care reform proposals. These principles all take into account that rehabilitation is, and should continue to be, an integral part of the health care system. They are:

A. Responsive

The needs of persons with disabilities must be taken into consideration. Providers of care for persons with disabilities and prevention of disability are an integral part of any heath care system and must be considered in a system and must be involved in all discussions about system reform.

B. Access

Access to health care should be available for all people without regard to age, income, disability or employment status.

C. Coverage

Any benefit package must include the appropriate rehabilitation components throughout the continuum of care. Rehabilitation is a vital part of the health care system and must continue to be so.

D. Quality Care

High quality care should be provided. Mechanisms that assure the services meet appropriate standards of quality must be included. These mechanisms might include measures of quality of life, functional status, and social integration.

E. Compensation

Rehabilitation providers should be compensated in all settings throughout the continuum at fair and adequate levels.

F. Cost Containment

Any system should contain the rapidly rising costs of health care delivery, insure more appropriate use of health care services, and promote greater efficiency in the health care delivery system.

G. Other

A health care system must include the following in a manner that isolates them from payment related to actual service delivery:

1. primary and secondary disability prevention;
2. health promotion;
3. public education and awareness; and
4. education and training of rehabilitation personnel.

## II. CHARACTERISTICS OF A REFORMED PAYMENT SYSTEM

The current system creates discomfort among all publics. Sporadic access to health care, limited resources, inconsistent coverage, and payment help highlight the need for a reformed payment system.

The principles outlined above suggest a set of characteristics which should be coordinated into any payment system. They need to be used in analyzing all proposals. The major characteristics specific to a payment system for medical rehabilitation are:

### A. Quality Promotion

Any new system must promote high quality care. Outcomes would be a measure of effective quality. These measures could be developed over the next decade and include specific components of quality of life, functional independence, and social integration. Incentives would be balanced by a quality component for the benefit of those receiving services. There would be no incentive to take easy cases disproportionately.

### B. Outcomes Focus

Outcomes would be a measure of a provider's services and continued ability to participate in the payment system. Outcomes would be on an aggregate versus individual basis in order to avoid not taking difficult cases that have potential for important gains. Payment would not be withheld in individual cases that did not meet outcome targets. For example, there is an outcome measure now under Medicare requiring that every two weeks the provider show the patient's improvement in order to continue coverage. Measures of outcome would be reproducible for patients and providers and be able to be reviewed for appropriate utilization.

### C. Classification System

To effectively use outcomes in a payment system, patients need to be classified by those that have similar outcomes and resource use. Two of the variables to use in a classification system are severity of the medical condition and status of the functional compromise. It would include incentives to take more severely involved patients.

### D. Incentives

Any reform system would include incentives for efficiency. If facilities have incentives they can develop resources to relate to their mission. These would include incentives to take severe cases.

### E. Payment

Any payment system must include an exceptions and appeals process.

### F. Periods of Coverage

Payments should be based on medical necessity of the event as apposed to being arbitrarily restricted in amount, by setting, or period of time because of inadequate resources.

STATEMENT OF THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. Chairman, my name is Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. I welcome the opportunity to testify on behalf of the approximately five million members and supporters of the National Committee on the critical issue of health care reform.

Nearly 36 million Americans, 16.6 percent of the non-elderly population, did not have health insurance coverage in 1990, according to the Employee Benefit Research Institute (EBRI). The number of uninsured Americans has increased by two million since 1988—or about one million a year. While some of this increase is due to population growth, most of the increase is due to a decline in employer-provided coverage. EBRI found that the number of employees covered through their employer has declined considerably—partly because of higher unemployment, partly because the high cost of premiums is causing employers to drop coverage. The result is that more people go without health insurance and more people are seeking coverage under Medicaid.

Everyone is feeling the effects of the increasing cost of health care. Employers have problems paying for health insurance coverage for their employees; States have serious problems paying for a Medicaid program which has increased by about 30 percent over the last few years; many people with health insurance coverage have trouble paying for increases in premiums.

One National Committee member experienced a more than 30 percent increase in his and his wife's medigap coverage. The two policies combined sent up from $2,460 to $3,320 per year. Such a large increase is serious for people living on fixed incomes—and perhaps even more serious for seniors living on a shrinking income. Many seniors depend on interest from their savings, and declining interest rates have taken a big bite out of their retirement income.

Americans want solutions to these health care problems. Younger people want to be assured of protection against the cost of illness. Seniors, uninsured for long-term care, want protection against the exorbitant costs of nursing home and home care. And everyone wants relief from escalating health care costs.

Mr. Chairman, as you have stated, your legislation, S. 1872, Better Access to Affordable Health Care Act, will not solve all of our health care problems. However, it does represent an important incremental step towards reform.

The National Committee fully supports the goal of comprehensive health care reform to guarantee health insurance protection as a right of every American regardless of income and age. National Committee members especially want a public long-term care insurance program. Long-term care is the health care problem which most severely impacts seniors and their families. If children or grandchildren lack coverage for acute care, it affects the entire family. If parents or grandparents lack coverage for long-term care, it affects the entire family. Both are necessary for full protection.

The National Committee supports financing of such proposals through a social insurance concept. Medicare trust fund dollars or dedicated payroll taxes should only be used to pay for Medicare or long-term care related benefits.

Several provisions in S. 1872 are particularly attractive to the National Committee. S. 1872 expands preventive care under Medicare such as annual mammograms and screenings for colon-rectal cancers. The National Committee has long supported such cancer screenings, because with early detection they save lives. Establishing a National Commission for Cost Containment to advise Congress and the Administration on ways to reduce health care costs also makes good sense. Such a commission could be very influential in proposing methods of reducing cost by streamlining billing systems, claims processes and other administrative expenses. We would only urge you to assure that the commission has broad representation including consumers, and that it be required to issue reports on a short, regular time frame.

Establishing meaningful Federal standards for small group insurance would help to correct some of the access problems now experienced by small employers. Likewise, we would encourage Federal standards for long-term care insurance products as you propose in your bill S. 1693. We particularly like the portability aspect of your S. 1872 reform proposal which allows employees with pre-existing conditions to receive coverage through a new employer. The National Committee supports community rating. Your bill will limit rate variations, especially those based on health conditions, but it will still permit some variation by age and sex. The National Committee is concerned that the age and sex variations make employment of older workers more costly.

In conclusion, the National Committee commends you, Mr. Chairman, for bringing this legislation to make incremental changes before the Congress in an effort to

move the debate on comprehensive health care reform ahead. The National Committee supports S. 1872 only as a first step towards true reform that includes long-term care, and looks forward to working with you and your staff in making comprehensive reform a reality. Thank you for the opportunity to express our views.

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## Statement of the National Organization of Physicians Who Care

Mr. Chairman and members of the Committee, thank you for the opportunity to discuss health care reform in the United States. Mr. Chairman, I especially want to thank you for your leadership in addressing this important issue. My name is Dr. Ron Bronow and I am President of the National Organization of Physicians Who Care. Our organization represents over 3,000 doctors in private practice.

We are a growing organization of physicians who believe in patients' rights and advocating those rights. We don't have some hidden, self-serving agenda. Our purpose is to attempt to preserve quality medicine and our patients' rights within an environment of cost cutting.

### PRESIDENT BUSH'S PLAN

Physicians Who Care believes that any serious health care reform proposal must consider several issues including: expanding health care coverage for all Americans; maintaining quality of care; allowing for patient choice; protecting the traditional doctor-patient relationship; and providing incentives for cost control in a quality medical environment.

President Bush's health care proposal has several components that deserve support and are included in the Physicians Who Care plan. Those provisions include reducing state mandated benefits; disallowing preexisting conditions in group coverage; and restricting malpractice cases.

However, the plan relies heavily on encouraging and almost pushing patients into so-called coordinated care programs or managed care programs, such as HMOs. The Bush Administration hope is that managed care will reduce costs.

That assumption is open to debate. There is little debate that managed care does reduce patients' choice, often provides incentives for doctors in such programs not to recommend further care or referrals to specialists, and can restrict access to medical technology. Managed care is all too often more concerned about costs and profits than patients.

A strength of American medical care is the choice that it allows patients. The providers of medical care in the United States have historically been physicians in private practice. The vast majority of physicians today are still in private practice. The managed care approach attempts to push both physicians and patients into HMOs and other such organizations. This type of care forces the physician into an untenable "gatekeeper" position, deciding on the type of care for a patient based more on limiting costs through capitation and other incentives rather than on the medical needs of the patients.

Managed care is not the answer to cost control or to providing quality medical care to more Americans. Some people are predicting that 40% of the population will be in HMOs by the year 2000, but I'd say that's a lot of wishful thinking.

Most people oppose restricting their choice of doctors. Today, only 36% of Americans would agree to go to a clinic to see an available doctor instead of their own private physician vs 50% in 1982. Only 30% of eligible employees choose HMOs.

The President's proposal would revoke regulations on HMOs which are protective of patients' rights. I and Physicians Who Care suggest a different approach. Before any more encouragement is given to managed care, HMOs and other managed care providers should disclose to the public and to their patients what financial incentives are provided

doctors to restrict services and to reduce referrals to specialists. Patients have a right to know about such incentives before they join an HMO, not after it's too late.

We physicians took a Hippocratic Oath to do our best for our patients. But, the HMO creates a basic conflict of interest for the physician. The physician is rewarded for deliberately limiting care, not for the good of the patient, but for generation of a profit for the corporation. An HMO that puts its physicians in a gatekeeper role by offering financial rewards or penalties for tests or referrals places physicians in an ethically and professionally untenable position. Physicians must feel free to make medical decisions based on the needs of the individual patient without fear of economic sanctions or reprisals.

When the General Accounting Office recently looked at Medicare HMOs they concluded that "the incentives of a capitation system may encourage the inappropriate reduction of necessary services." About 30% of Medicare patients disenroll within 2 years, not a very good indication of satisfaction with the plans

There has to be a better way than a doctor being paid more money to provide less care, all to increase the profit margin of large insurance companies. Our patients are not commodities to be bought and sold. We are talking about lives, not growth stocks. Rather than the President trying to push patients to doctors and groups that discount fees, why not consider rewarding good doctors as business leaders have learned in Cleveland. The government could save much more money by referring to physicians who practice conservative, high quality medicine than by looking for bargain basement doctors and HMOs.

Before looking at several other alternatives, I will point out that the Bush proposal for vouchers also does not effectively address the issue of rising costs. Unfortunately, too much of the Bush proposals are built on a concept of managed care.

"PAY OR PLAY" AND THE CANADIAN SYSTEM

One of the other health care proposals that is getting attention is the "pay or play" concept. An Urban Institute study concludes that 35% of employees currently covered would be shifted to the "pay" or public plan. Other estimates are even higher. Various legislative proposals would allow companies to pay 7% or 9% of payroll instead of buying health insurance. According to a Chamber of Commerce survey, employer medical costs averaged 9.9% of payrolls in 1990 while manufacturers' costs averaged 11.6%.

Once employers find out it's cheaper to pay than play, they'll pay. The result? - An instant Canadian medical system. So let's take a look at Canada.

The Canadian medical system is in crisis. You will likely see at least partial privatization as the money runs out.

In Canada, the government, not the physician nor the patient, makes basic health care decisions. The budget, not the needs of the patient, drives the system. Between 1986 and 1996 the federal government will have cut $30 billion out of health care, while seeing health care costs continue to rise.

As medical costs increase and payments from the Canadian federal government dry up, the provinces are telling hospitals that they won't pay any more for operating deficits. So, emergency departments in large hospitals in major Canadian cities have been shut down because of the lack of beds. Teaching hospitals can't purchase new equipment without cutting back on other services and medical schools are deleting courses. Funds for research have disappeared.

More and more Canadian hospital beds are being occupied by elderly patients who stay there longer than 60 days because their costs are well

below average. Everybody waits in line for surgery and diagnostic tests. Health care workers are unhappy. In the first 5 years of National Health Care, there were no days lost because of strikes or lockouts. That has changed. The average between 1985 and 1990 has been 175,000 person-days lost per year.

This year, Ontario physicians were given a take it or leave it deal. If the total costs of medical care incurred by consumers increase more than 1.5% in the next fiscal year, half of the increase will be deducted from the physician's future billings. That completely places the burden of medical inflation on the backs of doctors, particularly as Ontario health care costs continue to rise at an annual rate of 11-12%. Forget technology, forget the aging of the population, Ontario is now one large HMO and the doctors are the gatekeepers in charge of the rationing.

Michael Decter, the Deputy Minister of Health in Ontario, has set priorities for the provincial government. Recently he said, "There are four principal determinants of health: income distribution; broad public policy (that insures clean water and air, for instance); personal choice (on issues like smoking, for example), and treatments within the system. The problem right now is that we're putting all the money into treatment."

The article in which this quote appears continues, "Decter figures some health care dollars might be better spent on highway design or antismoking campaigns, which could save more lives than many existing health care services. Better to increase employment, goes the thinking of the NDP Cabinet, than to fund more bypass surgery." Perhaps, the House Public Works Committee here in Congress might appreciate that rationale about highways. But it sure is not medical care as we in the United States have understood it.

While Americans recognize that the problems of funding our present health care are serious, they are not willing to solve these problems by giving up their claim to first-class medicine, not to mention that $340 billion or more in new taxes, that one study estimated, would be needed for the United States to implement a Canadian-style health care system. That would make the United States one of the most highly taxed countries in the world. To fund it, either income tax or payroll tax rates would have to increase by at least 14 percentage points.

Now, if we don't pay for it, who will? The government? Considering the current budget deficit? And, do you know what's really absurd about national health insurance proposals -- casting the federal government as an efficiency expert.

Without even mentioning the other problems with the Canadian system, I would just like to close this part of my testimony with the following observation: Canada doesn't have to develop much of its own medical technology. It looks south to the United States for that. Under a Canadian type-system in the United States, where would the United States look for further advances in medical technology? South to Mexico or maybe across the Pacific to Japan?

PWC PLAN

Now that I've raised some of the problems with the Bush proposal, the pay or play concept and the Canadian system, I wish to share with you some approaches that can work.

One way to bring the 33 million Americans without insurance into the system is a nationwide mandate for employer-funded health care insurance. This coverage would protect two-thirds of the uninsured, 24 million workers and their dependents. If you extended it to the self-employed, it would protect 78% of the uninsured.

Right now, only 39% of businesses with 25 or fewer employees offer health benefits, because it's too expensive. And, most uninsured workers earn too little to afford their own private coverage. So, if we are going to ask small businesses to offer health benefits, we must offer a solution that's economically feasible.

As a starting point, we must make health benefits mandatory for all because only benefits that are mandatory are economically fair. If everybody has basic health insurance, then the costs of insurance and health care are shared equitably. Right now, people who are poor and uninsured get medical care for serious illnesses and accidents through emergency departments. So, then the rest of society pays the bill. Everybody pays more for medical insurance to cover those who receive benefits but haven't contributed to the insurance pool.

Mandatory benefits are economically sound. We can keep costs down only if everyone, including those at low risk for illness and accidents, is part of the insurance pool. In any kind of voluntary arrangement, low risk workers are going to opt out of the plan so that they can get higher wages or other fringe benefits. This adverse selection leaves the insurer holding the bag, covering only the higher risk employees, so everybody pays higher rates

High deductible

In order not to burden any employer unduly, however, mandatory insurance has to be available at a reasonable cost. This can only be done through a high deductible -- our number is $1,000, and provides basic coverage. All workers must be covered regardless of pre-existing illnesses, and rates must be based on community ratings. State mandated coverages must be eliminated.

A high deductible is essential for keeping costs down for two reasons: it discourages a credit card mentality (if medical care is free, overuse is inevitable) and, it provides greater value. At present, some employers offer low deductibles and co-payments. Why? Because employee groups demand that their health care benefits be paid from pre-tax dollars. But, since the insurance company pays the bill, neither the doctor nor the patient has any incentive to economize.

In Canada, the number of medical services per elderly patient has more than tripled since the institution of the national health program. An experiment conducted by the Rand Corporation involving over 5800 people over several years demonstrated substantial reductions in hospital use when patients paid for some of their care as opposed to the insurance company paying. But, under our present insurance system, most insured patients have no financial incentives to achieve savings.

A high deductible makes patients more responsible about health care decisions. It also provides more value for the money. Patients should pay for minor illnesses. Insurance should be for the serious problems. 10% of the population with serious or catastrophic illnesses account for 70% of our medical expenses. That's where insurance money should be spent.

Low deductible policies are expensive and employers often pay considerably more in premiums than any value the policies hold for their employees. If an employer was to lower the deductible from $250 to $100, each dollar of additional coverage would cost $2.14 in additional premiums. The annual premium saved by increasing the deductible from $100 to $1000 is over $1150 (male, age 40, in a city with high health care costs).

Considering how the money is being spent, it makes a lot more sense to reserve insurance coverage for major illnesses, but policies should have a cap limiting employee liability for physician and hospital expenses. Catastrophic coverage should be triggered when out-of-pocket costs exceed a certain percentage of adjusted gross income.

Employees who want to buy additional insurance could do so with after-tax dollars. But, basic coverage would not be limited to the employer-provided policy. It could be chosen from any other individually tailored plan. In either case, the employer would contribute the same amount. All $1,000 deductible policies, whether individual or group, would have the same tax benefits of not being taxable as income. That is the only way to make health insurance fair. There must be a level playing field, whether you are self-employed, work

in a gas station or for a large corporation, you should have the same tax benefits.

It is much easier to obtain health insurance as a member of a group than as an individual. Group insurance is usually issued without medical examination or other evidence of insurability of the individual members of the group. But, for individual policies it's another ball game. The underwriter evaluates every risk, looking at state of health, medical history, occupation and habits. Applicants are frequently rejected or the policies contain riders because of pre-existing illnesses. Small businesses, particularly those with older employees or employees with pre-existing illnesses, may find their premium rates pushed up to unaffordable levels. About 20% of applicants for individual health insurance receive substandard risk classification, leading to either a pre-existing illness exclusion or an above average premium.

Community Rating

A second important feature of our mandated insurance, then, is setting rates for basic coverage according to a community rating process. In this way, the insurer can apply a single rate or set of rates to a large number of people, greatly simplifying the process of determining premiums. There would be no adverse selection because the healthy wouldn't be able to opt out for other benefits.

Physicians Who Care believes that without community ratings there will be no future health insurance industry. By default the United States will be forced into a Canadian system. Discontent against current insurance practices (i.e., rapidly increasing premiums, rejection for previous illnesses and refusal to pay legitimate claims) is already at fever pitch.

The $1,000 deductible and community ratings are essential parts of the Physicians Who Care plan. Both together can make health insurance affordable for small businesses. Lower premiums will also bring back companies into the insurance market place which currently self-insure.

Eliminate State Mandates

We also have to eliminate state mandates in order to keep costs down. Over 700 laws have been enacted by state legislatures, mandating benefits for everything from drug and alcohol abuse treatment, chiropractic care, in vetro fertilization, to acupuncture, wigs and pastoral counseling. These mandates raise insurance rates by as much as 20%. According to one study, one out of four people lack health insurance because state regulations have priced it out of the reach of the employer.

Medisave Accounts

We realize that even small medical bills as well as the $1,000 deductible can overwhelm people with limited means. So, as an alternative to lower deductibles or having insurance companies pay small bills, we believe that special medical savings accounts known as medisave accounts should be established with pre-tax dollars. A medisave contribution up to $1000 a year would be a form of self-insurance. This would give workers direct control of their health care dollars and strong incentives to be prudent buyers in the medical market place. As medisave accounts increase, they would eventually become an important source of funds for purchasing additional health insurance or paying for uncovered medical expenses.

Now, the argument could be made that low income workers don't care about IRAs and wouldn't be able to afford deductibles. We can deal with this problem. Employers could be given tax credits to contribute to their employees' IRAs, or we could have refundable tax credits for the employees. Low income workers could be given cash payments to fund the IRA.

New Funding for Medicare

The graying of the population and the continued growth of technological innovation put increased pressure on Medicare. But, at the same time, the federal budget deficit threatens the health of the entire program. Over the past 10 years, the Medicare budget has been cut by more than $50 billion, but every year the Administration comes back and asks for more. Entitlement programs are always fair game during budget negotiations.

If Medicare premiums had initially been based on recipients incomes, the program would probably be self-sustaining today. But now when there is a deficit, the usual bureaucratic solution is either to cut the program or to raise taxes. We believe that there is a third solution.

The only way to protect the integrity of Medicare is to begin to change the nature of its funding. Instead of funding it entirely through taxes received each year, it could be partially funded through medical IRAs. An IRA would be a required purchase for every child in the first year of life. An IRA that costs $125 and earns 10% annual interest would accumulate to $65,000 by Medicare age. This money combined with that from the Medisave account could then be used to obtain private health care to supplement or replace government funds. Depending on family income, this one-time $125 payment could be partially or completely subsidized by the government. The funds accumulated in this reserve would not be used until the individual reaches 65 years of age unless he or she suffers a medical disability before that time.

Revamp Medicaid

Medicaid is another perennial headache. It was set up 26 years ago to provide the poor with health care, but now this joint federal/state health insurance program is experiencing severe financial difficulties. Between 1980 and 1989, the number of Medicaid recipients increased by only 9%, but the expenditures rose an incredible 123%.

As a sign of how serious the funding problem is, state governments and hospitals are now adversaries. The states cut the payments and the hospitals fight back in the courts. But law suits only deal with the symptom, not the source of the problem. Medicaid is in crisis for one basic reason. It dedicates almost half of its payments to long-term care. In 1986, 45% of total Medicaid spending provided only 7% of its eligible population with services in nursing facilities or institutes for the mentally retarded or mentally ill.

As the population ages, the problem will only grow worse. There is only one solution and that is to take long-term care out of Medicaid and change Medicaid eligibility requirements then long-term care could then be addressed as a problem that affects the entire population, not just the poor. The solutions will probably be a combination of private and public programs including tax relief to help families who pay for care of their elderly relatives, tax exemptions for long term care insurance, and a federal-state long-term care assistance program. Then Medicaid would be free to focus on the health care problems of the poor.

Medicaid should cover everyone below the poverty line. Persons just above the poverty line should be given the opportunity to buy an income-related package of primary preventive care as in the Hawaii S.H.I.P. program.

Scientific Guidelines for Medical Care

Most of our suggestions for controlling medical costs involve business, government and insurance companies. But, there is one area in which we physicians can and must take the lead, and that is in scientific guidelines for medical care. Rather than wait for the insurance companies to tell us how to practice medicine and set health benefits arbitrarily, primarily on the basis of costs, physicians must

set up these guidelines themselves because only physicians, not insurance companies, can change the way we practice medicine.

And whether we use local or national guidelines, we must have local validation. Only with this local validation will the greatest number of physicians participate.

Guidelines will give us strategies which will be based on accepted principles of good medical care. They should outline a whole range of appropriate tests and procedures for given clinical conditions. It still will remain the responsibility of the physician to choose what is best for the individual patient.

We must develop more effective mechanisms to assess cost effectiveness and cost benefits of new and existing technology. We should consider possible conflicts of interest when researchers evaluate technology in which they have financial interests. Physicians must fight all unethical practices (i.e., self-referral). If we defend these practices, how can we expect responsible people to respond to our proposals?

RBRVS (Resource Based Relative Value Scale)

Before concluding, let me raise one other issue that comes before the purview of this Committee in the health care area. That is the issue of RBRVS. The new HCFA rules on RBRVS will have the effect of restricting care for Medicare patients and reducing quality. Let me explain. This new method of paying doctors will change the way physicians get reimbursed for Medicare services.

Several studies have already been done. One comparison shows that family doctors will receive less for taking care of a patient than an auto mechanic or an air conditioner repairman will receive for fixing your car or air conditioner. Is this the value that you as Members of Congress want to place on the medical care of Medicare patients?

The American Academy of Home Care Physicians has completed a comparison of Medicare reimbursements for home visits. The figures show that a home health aide is reimbursed more that a physician for a home visit. All specialists are seeing huge cuts. CPT coding changes have eliminated any possible gains for cognitive services.

As physicians across the country see their overhead become higher than their Medicare incomes, many will refuse to see new Medicare patients. In fact, this is already happening. Many doctors with large numbers of Medicare patients will be pushed out of practice entirely. Others will be forced into HMOs. This will lead to the destruction of the private practice of medicine, the quality core of our medical system.

It looks like a dermatologist practicing in West Los Angeles may take about a 40% pay cut in the next 5 years because of RBRVS. Every year my practice expenses increase. What am I supposed to do? If I do more procedures, HCFA will say, "I told you so." If I see less Medicare patients, I will be accused of greed. If I shift costs from my Medicare patients, then the rest of society pays the bill. When insurance companies all switch to RBRVS, many more physicians will be driven out of practice. Was this the intent of Congress?

RBRVS creates an Eastern Europe style pay schedule which rewards volume rather than quality -- and compromises the integrity of the physician. Physicians Who Care will certainly bring this to the attention of our colleagues and our patients.

CONCLUSION

Physicians Who Care believes that by combining the proposals that I have outlined above that include an equitable mandated employer-funded insurance plan for catastrophic illness, a high deductible, individual "Medi-save" accounts (similar to what was recently proposed by a number of House Republicans), community rating of insurance and by privatizing

Medicare, the U.S. health care system can become better. More Americans will be covered. Costs can be curtailed. And Americans will continue to have choices in their medical care.

The vast majority of physicians are honest. We're not entrepreneurs. We don't refer to ourselves for profit. We don't unbundle our bills, cheat insurance companies, run Medicaid mills or write phony insurance reports. We practice medicine. The Physicians Who Care plan was designed to let us do our job the way we were trained. That's all we want.

To show our sincerity in wanting to curb health care costs, and as a service to society, we recommend that physicians devote one day a month to caring for persons who are unable to afford medical services. We have urged members of Physicians Who Care to donate their services to their communities, making no charges and accepting no payments. We let the community know that this is part of the Physicians Who Care volunteer program. We encourage all physicians to follow our lead.

We at Physicians Who Care have over 12,000 of our patients in Patients Who Care. We keep them well informed about their medical rights and our proposals. We have had tremendous positive feedback from our patients about the Physicians Who Care plan. Together, along with our patients, we are working to promote the fairest system for all.

Mr. Chairman, thank you for the including Physicians Who Care in these important hearings.

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